UNIVERSITY OF ALBERTA

"JACK OF ALL TRADES"-
GERONTOLOGICAL OCCUPATIONAL THERAPISTS
AS SPECIALIZED GENERALISTS

by

Jennifer Klein

A thesis submitted to the Faculty of Graduate Studies and Research
In partial fulfillment of the requirements for the degree

Doctor of Philosophy
In
Rehabilitation Science

Faculty of Rehabilitation Medicine

Edmonton, Alberta

Fall, 2007

Library and Archives Canada

Published Heritage Branch

395 Wellington Street
Ottawa ON K1A 0N4
Canada

Bibliothèque et Archives Canada

Direction du Patrimoine de l'édition

395, rue Wellington
Ottawa ON K1A 0N4
Canada

Your file Votre référence
ISBN: 978-0-494-32999-3
Our file Notre référence
ISBN: 978-0-494-32999-3

NOTICE:
The author has granted a non-exclusive license allowing Library and Archives Canada to reproduce, publish, archive, preserve, conserve, communicate to the public by telecommunication or on the Internet, loan, distribute and sell theses worldwide, for commercial or non-commercial purposes, in microform, paper, electronic and/or any other formats.

The author retains copyright ownership and moral rights in this thesis. Neither the thesis nor substantial extracts from it may be printed or otherwise reproduced without the author's permission.

AVIS:
L'auteur a accordé une licence non exclusive permettant à la Bibliothèque et Archives Canada de reproduire, publier, archiver, sauvegarder, conserver, transmettre au public par télécommunication ou par l'Internet, prêter, distribuer et vendre des thèses partout dans le monde, à des fins commerciales ou autres, sur support microforme, papier, électronique et/ou autres formats.

L'auteur conserve la propriété du droit d'auteur et des droits moraux qui protège cette thèse. Ni la thèse ni des extraits substantiels de celle-ci ne doivent être imprimés ou autrement reproduits sans son autorisation.

In compliance with the Canadian Privacy Act some supporting forms may have been removed from this thesis.

While these forms may be included in the document page count, their removal does not represent any loss of content from the thesis.

Conformément à la loi canadienne sur la protection de la vie privée, quelques formulaires secondaires ont été enlevés de cette thèse.

Bien que ces formulaires aient inclus dans la pagination, il n'y aura aucun contenu manquant.

Canada

ABSTRACT

Seniors will comprise about one quarter of the Canadian population by the year 2026 (Statistics Canada, 2005a). The impact of an aging population, along with: (a) the need for recruitment and retention of occupational therapists interested in gerontology practice, (b) the dearth of published articles examining experiences of therapists in the field, and (c) the lack of relevant research in a Canadian context, provided the rationale to investigate the experiences of gerontological occupational therapists. In this qualitative research study, I used an interpretive descriptive approach to examine the experiences of being a gerontological occupational therapist. Data from 16 participants were gathered by means of in-depth individual interviews and written responses to focused questions. Participants described working with older adults as an enjoyable experience which offers variety, intellectual challenge and satisfaction, yet this work was often assigned lower status.

A specialized generalist was the image that best portrayed this group of therapists who were required to have a wide breadth of knowledge, as well as in-depth specialized knowledge on the complexities of care and co-morbidities. The most predominant challenge faced by participants was the ageism that appeared to influence their abilities to be fully valued within their work settings. This ageism appeared to be socially produced in response to influences of powerful discourses such as 'rehabilitation' and 'independence' as well as public and professional attitudes. These social productions in turn impacted service allocation, social structures and older adults' persona. Adaptive communication skills along with the 'right attitude' of being empathetic, compassionate,

and enjoying visiting and listening to the stories of their older clients were deemed crucial attributes when working as a gerontological occupational therapist. From these experiences, a conceptual framework was developed outlining key influences relevant to the experiences of occupational therapists who work with older adults. This framework provides occupational therapists with a deeper understanding of the various aspects related to working with older adults. The acquired knowledge from this study can foster dialogue on issues of gerontological practice which is needed to develop appropriate programs and strategies to attract, promote, and retain more occupational therapy professionals in gerontology.

DEDICATION

To all the gerontological occupational therapists… the impact of your job is greater than you will ever know.

To Emma, Katie and our third child that is kicking in my belly as I write this …
Believe in yourself and you can do anything that you set your mind to.
AND
Balance in life will generate success.

ACKNOWLEDGEMENTS

I am most grateful to Dr. Lili Liu, my advisor, mentor and friend; whose listening heart and kind encouragement saw me through thick and thin over the last six and a half years. Her suggestions, perspectives and support allowed me to gain a fuller understanding of the amount of time and work necessary to devote to creating such an extensive academic paper. She guided me through various critical points with a clear big picture, as I at times, worked at a microscopic level within a sea of data.

To my committee members- Dr. Herb Northcott, Dr. Sheree Kwong See, Dr. Gill Chard- who provided their expert review, constructive feedback, and their own unique perspective throughout my studies. They continuously encouraged me to delve deeper into issues and think more critically; all the while doing it in a very supportive manner. It has been a privilege to work with each of them.

To Dr. Marcia Finlayson, the external examiner for her time, endorsement and support of the thesis and the constructive feedback provided.

To Dr. Vivien Hollis, who provided her time, expertise and insights as an experienced qualitative researcher.

At a personal level I am fortunate to be surrounded by such loving family and friends who supported me throughout the entire journey. I am forever indebted to my husband, Doug, whose support and encouragement were never ending. He is truly the light and love of my life. He has spent endless hours holding down the fort so that I could complete this dissertation. And to my children Emma and Katie who brought tremendous joy and balance in my life while I completed my studies. To the rest of my family: mom and dad, my brothers- Chris and Mike and their partners Joanne and Lynne, Rose and Tony, Tanya and Ron. My family gives me strength and unconditional love.

There are also my colleagues, Michael and Eric, who travelled through this doctoral journey with me. I am so grateful that we all started in the same year. The doctoral study experience would not have been as good without you guys. Our friendship and bond will last a lifetime. Thank you for sharing this experience with me. I *know* you understand.

To my dear friend Tammy for her support, advice, editing, critical questions and having the gift to make me laugh. To my other friends, Julie, Cheryl, Cindy and my 'Mom's Group'- who gathered around and made it possible for me to still engage in the research realm while enjoying the fullness of life.

To the 16 occupational therapists who generously offered their time and insight in order to make this study possible.

I would also like to express my gratitude for the financial support provided by Canadian Occupational Therapy Foundation's Doctoral Fellowship, Sir Izaak Walton Killam Memorial Scholarship, University of Alberta Dissertation Fellowship, Andrew

Stewart Memorial Graduate Prize, Province of Alberta Graduate Fellowship, Royal Canadian Legion Gerontology Fellowship, Canadian Federation of University Women Margaret Brine Scholarship and the Soroptomist International of the Americas' Western Canada Region Fellowship.

I truly believe the journey we all shared was one worth taking.

TABLE OF CONTENTS

CHAPTER ONE: INTRODUCTION 1

Gerontological Coverage in Occupational Therapy Publications 2
Attitudes towards Older Adults 5
Experiences of Being a Gerontological Health Professional 7
Rehabilitation and Occupational Therapy 10
Rationale for the Study 12
Purpose of the Study 13
Research Questions 14
Definition of Terms 14

CHAPTER TWO: METHODOLOGY 16

Qualitative Research 16
Data Collection Strategies *17*
Interpretive Description 19
The Interpretive Paradigm *19*
The Approach: Interpretive Description *19*
Challenges to Using Interpretive Description *24*
Rationale for Chosen Methodology *25*

CHAPTER THREE: PROCEDURES 27

Role of a Researcher 27
Personal Reflections as the Researcher 31
Data Collection Procedures 37
Introduction *37*
Participants *37*
Procedure for Interviews *43*
Participant Characteristics *45*
Data Analysis Procedures 46
Criteria for Rigour 50
Narrative Structure 54
Personal Significance 54
Ethical Considerations 55
Summary 56

CHAPTER FOUR: EXPLORING THE EXPERIENCES OF GERONTOLOGICAL OCCUPATIONAL THERAPISTS 57

Introduction 57
Becoming a Gerontological Occupational Therapist 58
Experiences of Occupational Therapists Working with Older Adults 60
Sentiments about their Job *64*
Client Characteristics *65*
Environmental Influences *95*
Attributes 142
Gerontological Pearls – Participants' Advice for Working with Older Adults 149
Career Plans 151
Summary of Results 153

CHAPTER FIVE: GERONTOLOGICAL OCCUPATIONAL THERAPISTS AS SPECIALIZED GENERALISTS 155

Ageism 156
Ageist Discourses *159*
Ageist Attitudes in our own Backyard *165*
Social Impact of Discourses and Ageist Attitudes *170*

Confronting the Challenges *175*
KEY ATTRIBUTES FOR GERONTOLOGICAL OCCUPATIONAL THERAPISTS 182
GENERALISTS VERSUS SPECIALISTS 185
Merits of Specialists *186*
Merits of Generalists *188*
Where do we go from here? *189*
LIMITATIONS OF THE STUDY 195
IMPLICATIONS FOR PRACTICE, TEACHING AND RESEARCH 196
CHANGES EXPERIENCED BY THE RESEARCHER 201
SUMMARY 203

REFERENCES 206

APPENDICES 227

APPENDIX A- INFORMATION SHEET FOR INTERVIEW 228
APPENDIX B- FOCUSED QUESTIONS 230
APPENDIX C-CONSENT FORM 231
APPENDIX D- INTERVIEW GUIDE 232
APPENDIX E- PARTICIPANT DETAILS 233
APPENDIX F- INSPIRING STORIES 234
The Determined Spirit *234*
Listening for a change *235*
The mentor, the mentee and the OT *235*
A cup of tea changes everything *236*
The Easter Message *236*
Freedom equals Dim Sum *237*
Celebrating an ingenious invention *238*
So long as they are dirty, they are happy *238*
APPENDIX G- PARTICIPANTS' NUMBER CODE 240

LIST OF TABLES

Table 1: Key attributes for gerontological occupational therapists.....143

LIST OF FIGURES

Figure 1: Example of a theme with its categories and codes 49

Figure 2: Conceptual framework depicting the multiple factors influencing the experiences of gerontological occupational therapists.....62

CHAPTER ONE: INTRODUCTION

The significant growth in the proportion of people aged 65 and older is a widespread phenomenon in the world. Currently in Canada, seniors comprise 14.7% of the population (Statistics Canada, 2005a). Demographic projections indicate that the proportion of seniors will rise to about one quarter of the Canadian population by the year 2026 (Statistics Canada, 2005b). The increasing numbers of older adults will have a notable impact on future health care demands. Seniors are major consumers of health care. Compared to their younger counterparts, they have twice as many hospital stays per capita, and the hospital stays last twice as long (Miller, 1998). In addition, seniors have higher incidences of physical and cognitive impairments that limit their function and ability to complete daily activities (National Advisory Council on Aging, 1999). A significant proportion of this older population will be members of the fastest growing cohort, the 'oldest old' who are aged 85 years and older. This group has the highest rates of disability, nursing home use, and multiple chronic conditions (Klein, 1997; Thomas, 2002). Demographic projections, along with the increasing prevalence of disability associated with aging indicate that the older adult population will become an increasing proportion of the occupational therapy clientele.

Working with older adults will become a certainty for the majority of occupational therapists in the future as increased numbers of seniors access health care services. Currently 60% of Canadian occupational therapists report working

with older adults (Canadian Association of Occupational Therapists (CAOT), 2005a). The proportion of occupational therapists working with this population has increased 88% in one decade (Klein, 2002). Questions have been raised regarding health care professionals' readiness to meet the future demands of the senior population and are fuelled by reports suggesting reluctance by health professionals to work with older adults (Dunkle & Nosse, 1998; Nosse, 1995; Wilkins & Rosenthal, 2001).

Despite the significant number of occupational therapists working with older adults, there is a paucity of information on the actual experiences of working with this population. Several aspects related to these experiences are discussed in the literature. These include gerontological coverage in occupational therapy publications, attitudes of health professionals working with older adults, experiences of being a gerontological health professional, and the relationship between rehabilitation and occupational therapy.

Gerontological Coverage in Occupational Therapy Publications

Initial recognition of gerontological occupational therapy began in the 1940s, when demographics reflected a lengthening of the human life span from 42 years in 1900, to 65 years in 1940 (Foti, 1996). In 1947, Hildenbrand published one of the first occupational therapy articles that examined age-related issues. Hildenbrand outlined occupational therapy goals to promote improved health and prolonged life span for seniors. In the 1950s, the Canadian Journal of

Occupational Therapy published proceedings from a symposium on geriatrics. Within this, Kurtland (1952) provided a summary of a therapy program at Sunnybrook Hospital in Toronto that included daily occupational therapy for seniors. This program incorporated many occupations into clients' therapy including oil painting, typing, gardening and discussion groups. In the 1960s and for the first time, Willard and Spackman's (1963) third edition of *Occupational Therapy* included a chapter on occupational therapy in geriatrics (as cited in Foti (1996). Reflective of these earlier years, the 25-year cumulative index of the American Journal of Occupational Therapy for the period of 1947-1971 had 34 articles listed under its gerontology subheading. These earlier works indicated an emerging interest in gerontological issues and service provision by occupational therapists.

In the mid 1970s there was a significant increase in gerontological occupational therapy publications (Foti, 1996). In a 1988 position paper, the Canadian Association of Occupational Therapists endorsed the role of occupational therapists with older clients (CAOT, 1988) and Hasselkus and Kiernat (1989) identified gerontology as an occupational therapy specialty in the United States. Several years later the role of gerontological occupational therapists was continuing to be defined (Hasselkus, Dickie & Gregory, 1997), even though experts had written extensively on the contribution of occupational therapists to the health and well-being of older adults (see Crabtree, 1991; Hasselkus & Kiernat, 1989; Hobson, 1999a; Rodger, 1984). Gerontological practice has

expanded the view of its clients beyond the rehabilitation approach to include educational and adaptation approaches. An educational approach enables older adults to improve their knowledge and skills by providing appropriate teaching, practice and experiences related to their evolving circumstances (Hagedorn, 1997). An adaptation approach enables older adults to incorporate changes and adjust to the changes of their occupations (Hagedorn, 1997).

Key studies have been published on the effectiveness of occupational therapy interventions for older adults. Carlson, Fanchiang, Zemke and Clark (1996) published a meta-analysis that demonstrated that occupational therapy intervention is effective in improving functional and psychosocial parameters in older adults. One year later, Clark et al. (1997) published results of a randomized controlled trial affirming the effectiveness of occupational therapy preventative programs for independent community dwelling older adults. The gerontological specialty is gaining credibility within the profession as an important aspect of occupational therapy services.

The general rehabilitation and occupational therapy text books related to aging examine a variety of topics including aging theories, psychological and physical aspects of aging, and more recently issues such as elder abuse and sexuality (see Bonder & Wagner, 2001; Davis & Kirkland, 1988; Kauffman, 1999; Kiernat, 1991; Lewis, 2002). This is consistent with findings in a recent survey on the status of gerontological content in entry-level occupational therapy programs in

Canada, in which respondents reported that the most common topics addressed in curricula were the physical and cognitive aspects of aging and occupational therapy interventions for older adults (Klein, 2002). Absent from these textbooks is a discussion of interpretations of the research literature on the experiences of occupational therapists who work with older adults. This information would help equip future occupational therapists with knowledge about the challenges and rewards of working with older adults and allow students to make informed choices about whether or not a career in gerontological occupational therapy is an optimal fit.

Attitudes towards Older Adults

To gain a better understanding of the experiences of gerontological occupational therapists one must consider the published literature on the attitudes of occupational therapists towards older adults. The literature indicates that working with seniors has been devalued and assigned low status (Horowitz & Bressler, 2000). Hobson (1999a) argued that there is a "pervasive but subtle discrimination" against older adults and a belief that treatment is fruitless for this population, this belief is also known as "therapeutic nihilism" (p.15). Although the author did not explain why this perception is pervasive, it may be related to ageist societal views (Palmore, 1999) that are often directed towards the senior population. These views are subsequently reflected in the attitudes of some health professionals.

Negative perceptions have been identified in the literature as being barriers to a variety of health professionals' decision to work with older adults. These perceptions include limited interaction with professional team (Dunkle & Hyde, 1995), a narrow scope of experiences (Dunkle & Hyde, 1995), lower salaries (Coren, Andreassi, Blood & Kent, 1987; Dunkle & Hyde, 1995), and belief that continuing in the gerontology practice would lessen their ability to get future jobs (Wilkins & Rosenthal, 2001). Health professionals' perceptions of older adults can include an expectation that the older person is dependent (Spier & Yurick, 1989), belief that older adults are less motivated than other clients, and the belief that older clients have numerous chronic pathological conditions (Coren et al., 1987). Previous research also suggests that health care workers are particularly susceptible to projecting negative attitudes about older adults because they have continual exposure to infirm and ill seniors (Bond, 1992, Kirk 1992; Lookinland & Anson, 1995). This long term exposure may not pertain to all occupational therapists because some therapists focus primarily on health promotion and prevention among the well elderly population.

Fortunately, the picture is not entirely bleak. Todd, Rider, and Page-Robin (1987) found that occupational therapy student attitudes about older adults were predominantly positive and increased knowledge about older adults was a factor associated with positive attitudes. Thus, a program that increases student occupational therapists' awareness about aging may have a positive impact on their attitudes towards working with older adults. Ageist attitudes and stereotypes

can be barriers to recruiting and training occupational therapists to work with older adults (Wilkins & Rosenthal, 2001). Beyond outlining the negative attitudes perceived by gerontological occupational therapists, it is important to know what gerontological occupational therapists perceive as positive aspects in order to promote working in this specialty field.

Experiences of Being a Gerontological Health Professional

Database searches revealed just a handful of studies that explored different health disciplines' experiences of working with older adults. Some of this work was completed in medicine. Cravens, Campbell and Mehr (2000) used in-depth interviews and a grounded theory approach to identify how academic geriatricians explained their decision to enter geriatrics and what they saw as the field's positive aspects. From this qualitative study, six themes emerged: (a) experiences that fostered learning about respect, integrity and responsibility, (b) valuing personal relationships, (c) a perception of seniors being distinctively different from younger populations, (d) a desire to feel needed personally and societally, (e) democracy of a team approach, and (f) intellectual challenges. They recommended further research to examine the positive aspects of a career working with seniors. Adams et al. (2002) also used interviews with a grounded theory analysis, to explore American physicians' experiences of working with seniors and the difficulties they encountered. From this study a framework was developed and three major domains of difficulty emerged: (a) medical complexity and

chronicity, (b) personal and interpersonal challenges (e.g., communication barriers), and (c) administrative burden related to Medicare regulations.

Consistent with other health fields, occupational therapy researchers have published few studies examining the experiences of occupational therapists working with older adults. Hasselkus, Dickie and Gregory (1997) published a paper in which they examined the occupational therapists' experiences with older adults. This was part of a larger study that was published in 1994, where Hasselkus and Dickie conducted a study with the aim of providing a better understanding of general occupational therapy practice and the dimensions that constitute practice. They used a phenomenological approach to examine the meaning of satisfying and dissatisfying occupational therapy practice across all realms. From their findings, Hasselkus at al. (1997) suggested that occupational therapists who work with seniors value the "here and now" and "accept the older clients' movement toward death" (p.139). A major component of occupational therapists' satisfying moments of working in this area was returning a person to a former level of function or former place of residence. However, this perspective highlighted the mismatch of the traditional rehabilitation approach with the needs of older adults. With older adults, a rehabilitation approach is not always possible or realistic. Hasselkus et al. (1997) urged further research to explore this conflict between the rehabilitation ideology and the practice of occupational therapy with older adults.

Some limitations must be noted regarding Hasselkus' et al. (1997) gerontological study. First, Hasselkus et al. (1997) recruited their participants using a nation wide survey in the United States and included a diverse group of practicing occupational therapists. The respondents who were included in the geriatric subset did not necessarily identify themselves as working primarily with seniors (B. Hasselkus, personal communication, January 20th, 2003). Individuals were included if they made reference to an older client in the interview. Thus, the sample of respondents may have included therapists in general practice with clients of all ages, not primarily the senior population. The resulting survey sample may have different perspectives than occupational therapists whose work is focused on older adults. For example, a therapist working with clients of all ages may have a different view of working with seniors than therapists who work primarily with seniors. Second, the themes used for the gerontological article were not derived uniquely from the participants working with older adults. They were taken from Hasselkus and Dickie's earlier 1994 study examining general occupational therapy experiences. Using themes derived from a general population could potentially bias the examination of the experiences of gerontological occupational therapists by forcing them to fit into previously developed themes. Third, the study was conducted in 1988, 19 years ago. While data from the 1994 and 1997 studies provide relevant information for practice, therapists working in Canada in the 21st century may have very different experiences due to different historical, socio-political and cultural climates than the American participants from earlier studies.

Rehabilitation and Occupational Therapy

The philosophies and goals of occupational therapy are traditionally embedded in the rehabilitation approach (Friedland, 1998; Hasselkus, 1989a). This rehabilitation approach evolved within the positivist paradigm and focused on the restoration of clients to their former levels of functioning (Imrie, 1997). Hasselkus (1989a) argued that "rehabilitation is considered a process which has a beginning and an end, i.e., treatment can reach 'completion' and the patient can be declared to have reached maximum benefit" (p. 6). This reductionistic view focuses on lost function and excludes wider issues. In an extensive literature search I discovered very little written about the paradox between rehabilitation and working with older adults. Occupational therapists working with older adults potentially face a contradiction between the principles and assumptions of rehabilitation-oriented practice and the needs and experiences of seniors. A concern with this rehabilitative perspective is the way in which it fails to account for the differences between older clients' health care needs and the needs of younger people (Moloney & Paul, 1991). Specifically, older adults have more chronic diseases than their younger counterparts (Williams & Botti, 2002). Chronic diseases are not curable and thus, many older adults are not able to return to their former level of functioning, a central tenet of the traditional rehabilitation approach. As well, recovery times of older adults are typically longer than those of younger clients (Kauffman & Jackson, 1999). These important differences may lead to frustrations for occupational therapists working within the traditional rehabilitation framework. In their study examining the meaning of satisfying and

dissatisfying practice of occupational therapists working with older adults, Hasselkus et al. (1997) identify this mismatch of ideologies between the traditional rehabilitation approach and the approaches used by occupational therapists with older adults.

The potential incompatibility of using a rehabilitative approach with all seniors is exemplified in everyday occupational therapy practice. Clients who have serious impairments in physical, cognitive, mental functioning, or any combination of the three, may be bedridden, unable to care for themselves, or unable to perform basic activities of daily living. Thus, they have little chance of returning to 'normal' functioning or of being 'cured'. However, they can still benefit from occupational therapy interventions. As well, even with a common illness like depression, recovery is difficult to conceptualize within this rehabilitative model.

Clients who have shown few clinical signs of recovery in the first six weeks of rehabilitation can still benefit from service. As well, service can still be beneficial if findings of outcome measures reveal that there has been no change in the functional abilities of a client. That is, outcome measurement tools may not be sensitive to change that occurs as a result of rehabilitation services. Even if there is no improvement, a person may benefit from the occupational therapy focus of maintaining abilities and preventing or slowing decline. In instances where the individuals are in palliative care, therapists can make a difference in the lives of their clients. For example, pain levels can be reduced, compensatory strategies

can be incorporated, and support can be provided to clients to come to terms with their mortality and prepare for death. Although death is imminent, the quality of the person's remaining life can be enhanced by occupational therapy (Prochnau, Liu & Boman, 2003).

Major redefinitions of health care include a consideration of health promotion and a client-centered focus in occupational therapy (Reed & Sanderson, 1999), which enables an optimal level of well being and quality of life for individuals with chronic diseases. As Friedland (1998) proposed, using occupation, occupational therapists have a unique and powerful tool not to cure, but to positively influence health and well being. The profession now recognises important outcomes other than restoring function, such as focusing on functional goals, family context, and client autonomy (Hasselkus, 1989a). This change in perspective is necessary when working with older adults. Maintaining or minimizing deterioration and enhancing quality of life must be viewed as successful outcomes, when the health of older adults with complex medical issues is considered. The perceptions of gerontological occupational therapists regarding the rehabilitation ideology and its' compatibility with seniors, as well as the impact it has on therapists' daily practice has not been the focus of research studies.

Rationale for the Study

Based on the literature review, little information exists to provide a comprehensive understanding of the experiences of occupational therapists

working with older adults. The increase in the older adult population, the need for capacity building within gerontological occupational therapy practice, the dearth of published articles on experiences of therapists in the field, along with the lack of relevant research in a Canadian context, make it necessary to further investigate the experiences of gerontological occupational therapists. One approach to gathering this information is to listen to occupational therapists' stories about working with seniors. Kiernat (1991) urged therapists working with older adults to "pass on their excitement and convey to students and fellow therapists the challenges and the rewards of working with older adults." (p.9). More than a decade later, the challenges and rewards of working with this population have yet to be examined within a research study.

Purpose of the Study

The purpose of this study was to examine the experiences of occupational therapists who work with older adults. In doing so, this study provided insights into the rewards and challenges of working with older adults to help prepare occupational therapists for practice and progression within this specialty. This study initiated the discovery of the common or essential themes associated with being a gerontological occupational therapist. The perceptions and meanings of practice held by gerontological occupational therapists were examined by drawing on evidence gathered from in-depth interviews as well as written responses to focused questions.

Research Questions

This qualitative study was guided by two questions:

1. What are the experiences of being a gerontological occupational therapist?
2. What attributes (i.e., knowledge, skills and attitudes) do gerontological occupational therapists consider crucial for practice with seniors?

These research questions were under continual review and reformulation throughout the study.

Definition of Terms

Three terms need to be defined as a foundation when discussing occupational therapists who work with older adults- *geriatrics, gerontic, and gerontology.* These terms are often used interchangeably, however there are differences between them. According to Merriam-Webster's Dictionary (2003) the term 'geriatric' is defined as "a branch of medicine that deals with the problems and diseases of old age and aging people." 'Gerontic' on the other hand, is defined as "of or relating to decadence or old age." The term 'gerontology' is defined as "the comprehensive study of aging and the problems of the aged." 'Geriatric occupational therapist' and 'Geriatric population' are commonly used in the literature (e.g., Bonder & Wagner, 2001; Kauffman, 1999; Lewis, 2002). 'Geriatric' implies illness and disease, which is not reflective of the broad scope that occupational therapy encompasses. While 'gerontic' is a general term relating

to aging and used by some authors (e.g., Davis & Kirkland, 1988; Lewis, 2002), 'gerontology' best reflects the broad bio-psycho-social perspective that occupational therapy encompasses in the context of seniors. Therefore, I argue the term 'gerontological occupational therapist' is more aptly applied to the occupational therapist working with this population.

CHAPTER TWO: METHODOLOGY

This chapter presents an overview of qualitative research and a specific discussion of the interpretive descriptive approach. Within the discussion of interpretive description several areas were explored. These include the interpretive paradigm, principles of interpretive description, and challenges and rationale for using this method of inquiry.

Qualitative Research

If a phenomenon needs to be understood and little related research exists, then, as Creswell (2003) proposed, study of this phenomenon merits a qualitative approach. Qualitative design, highlighted in a special edition in the *American Journal of Occupational Therapy (*see Hasselkus, 2003), is a field of inquiry in its own right. "It crosscuts disciplines, fields, and subject matters" as reported by Denzin and Lincoln (2000, p.2). In 1995, Lincoln, an expert of qualitative methods, contended that "the entire field of interpretive or qualitative inquiry is itself still emerging and being defined" (p275). I would argue that this is still the case 12 years later, as evidenced by the editorials and discussion papers in such prominent journals as *International Journal of Qualitative Method* and *Qualitative Health Research.*

Creswell (1998) suggested that qualitative research is useful when the researcher does not know the important aspects of a phenomenon that need to be examined. In addition, questions related to personal experiences necessitate a qualitative

method of inquiry. This type of inquiry helps us form understandings of human experiences and impart these understandings to wider audiences (Cohn & Lyons, 2003). Qualitative approaches thus have potential to produce findings that can truly be reflective of the actual lived experiences of participants, a form of internal consistency that is a strength of the qualitative approach to research (Patton, 2002). The knowledge that emanates from qualitative research often challenges our assumptions about the way we see ourselves as therapists and opens our eyes to new ways of seeing that which is already familiar to us (Hasselkus, 2003).

Holliday (2002) suggested that based on the kinds of questions asked, several strategies of inquiry exist within qualitative research. He lists the following: case study, ethnography, phenomenology, ethnomethodology, action research, and grounded theory. In addition, there are other traditions including life histories (Strauss & Corbin, 1990), conversational analysis (Strauss & Corbin, 1990), clinical research (Denzin & Lincoln, 1994) and interpretive description (Thorne, Reimer Kirkham & MacDonald-Emes, 1997).

Data Collection Strategies

Within these orientations, a number of data collection strategies are available. These strategies do not fall into a generally accepted classification, but the major ones include observations, interviews, and analyzing documents and audio visual material (Creswell, 2003). Relevant to the current study, face-to-face interviews and document analysis will be discussed in more detail. Combining multiple

sources of information allows one to check and validate findings. As well, Patton (2002) suggested multiple sources of information can compensate for the weaknesses of a single approach.

Face-to-face interviews

Polit and Hungler (1999) argued that face-to-face interview is the most respected method for securing participant information. This type of interview allows the researcher to encourage in-depth accounts, verify and clarify information.

There are some limitations to using interviews to collect data. There may be variation in participants' abilities to articulate and share their perceptions and reflections (Patton, 2002). As well, the researcher's presence may bias participants' responses. However, the benefits of interviewing participants face-to-face outweigh the limitations. Interviewing enables participants to share their ideas and perceptions of the way they make sense of their lives. Compared to telephone interviews, the face-to-face strategy compels more small talk, joking and asides in which people can more fully express their ideas and opinions (Shuy, 2002). This naturalness leads to open expression and comfort. In addition, face-to-face interviews not only gives access to articulated speech, but also to non-articulated body language (e.g., gestures, posture, facial expressions) (Polit & Hungler, 1999). Body language may both reinforce and weaken what is said, or may even communicate a conflicting message with what is expressed verbally.

Document analysis

Records, documents, artefacts and archives are all viewed as items that may be used for document analysis (Patton, 2002). Analysis of written documents is another method for gathering rich data and enables further identification of issues. While documents can vary in quality and completeness, they can reveal information that cannot be observed. When an individual has the opportunity to write something, this is a private action which can encourage reflection and sometimes provide different information than that found in an interview. Document analysis can also provide a stimulus for paths of inquiry that can be pursued only though direct observation and interviewing (Patton, 2002).

Interpretive Description

The Interpretive Paradigm

Over the last half century, a paradigm emerged contrasting the principles of positivism. With its emphasis on understanding the social world from the viewpoint of its participants, it can be referred to as the interpretive paradigm. Containing such qualitative methodological approaches as phenomenology, narrative inquiry, and hermeneutics, it is characterized by a belief in a socially constructed, subjectively-based reality, one that is influenced by culture and history (Higgs, 2001).

The Approach: Interpretive Description

In the early 1980s, there was focus on methodological purity. Qualitative researchers felt they had to adhere to the rules that were set out by the original theorists (Thorne, 2005). If they did not, it was seen as a sign of intellectual weakness and was not considered good science. Applied health disciplines implemented the rules and tenets that were associated with methods from the social sciences. However, sometimes the fit was not suitable. At times, health researchers modified the dictated rules of standard methodologies (e.g., grounded theory, phenomenology, ethnography) (Thorne, Reimer Kirkham & O'Flynn-Magee, 2004). This was done because of the nature of their questions, a tendency to ask practical clinical questions rather than social theorizing questions that were asked by cousins in sociology and psychology (where grounded theory, phenomenology, etc. originated) (Thorne et al., 2004). These altered approaches had the potential to be used incorrectly, also known as 'method slurring' (Thorne et al., 1997), which may be more aptly termed 'methodology slurring' referring to a blending of different philosophical approaches. Even the experts of the traditional methodologies expressed this concern. In the second edition of their book on grounded theory methodology, Strauss and Corbin (1998) provided some limitations of grounded theory, particularly the idea that grounded theory procedures are overly rigid, structured, and thus constraining. They suggested that researchers be more open and flexible adapting the procedures to different phenomena, theoretical backgrounds, and research settings.

Responding to an expressed need for an alternate method, Thorne et al. (1997) named and explicated interpretive description as a generic qualitative descriptive approach. In essence, interpretive description was not a new tradition. This methodological tradition legitimized the body of qualitative research that had already emerged within the health sciences, but whose traditions, as Morse (1991) argued, had yet to be given a name. Interpretive description is similar to other qualitative descriptive approaches such as Sandelowski's (2000) 'qualitative description' and Caelli, Ray and Mill's (2003) 'generic qualitative research'. Each of these labels suggests that normal traditions have been quite useful, but some research questions do not fit into their rigid guidelines. Interpretive description admits that the traditional approaches are often being modified. This generic approach has some structure but not so much that it too would be used incorrectly. Similar to the traditional approaches, it still demands rigor and thoughtful logic.

The foundation of interpretive description is as Thorne et al. (2004) suggested, "the smaller scale qualitative investigation of a clinical phenomenon of interest…for the purpose of capturing themes and patterns within subjective perceptions and generating an interpretive description capable of informing clinical understanding" (p.5). The interpretive descriptive approach is used when little information exists regarding a phenomenon in order to generate knowledge and a better understanding of the experience. It creates a logic trail by which the rationale of a study directs the methodological decisions, rather than textbook decisions, such as can be the case with the use of some other qualitative methods.

Currently, there are no published occupational therapy studies using interpretive description. However, it has been used in other applied disciplines, primarily nursing, since its inception in 1997. Interpretive description can contribute to our profession by providing an approach that is inductive and allows us to extend beyond the individual to understand commonalities within a range of instances of a phenomenon, all the while encouraging findings to have practical clinical implications (Thorne et al, 2004).

Analytic Framework

The philosophical framework of interpretive description is based on the interpretive naturalistic orientations, where there are multiple realities, yet at the same time shared realities amongst individuals (Thorne et al, 1997). Thorne et al., (2004) further suggested that this approach has other key axioms. First and foremost, the researcher must accept the job description that Morse (1994) laid out of comprehending data, synthesizing meanings, theorizing relationships, and recontextualizing data into findings (Thorne et al., 2004). In addition, the inquirer and the 'object' of inquiry interact to influence one another. Another tenet is that it provides practical findings that can be used to inform clinical practice (as opposed to those approaches which focus on advancing social theory).

Thorne et al. (1997) incorporated several general principles from other researchers into their analytic frameworks. To enter into a study blindly, with no knowledge about the subject is viewed as counterproductive (Morse, 1994). Interpretive

description encourages a critical analysis of existing knowledge prior to commencing the study. Similar to Mitchell and Cody's (1993) suggestion, interpretive description should be "located within the existing knowledge so that findings can be constructed on the basis of thoughtful linkages to the work of others in the field" (Thorne et al., 1997, 173). This is in contrast to phenomenology where knowledge is grounded in the experiences of everyday world (van Manen, 1997). Thus, in phenomenological studies, pre-conceived concepts and knowledge regarding the phenomenon are avoided. Similar to Schultz and Meleis' (1988) beliefs, Thorne recommended using a variety of existing knowledge for the foundation to a specific research study. Researchers can combine formal research along with clinical knowledge.

Sample selection

Thorne at al (1997) recommended using theoretical sampling which refers to a type of sampling based on concepts that have proven theoretical relevance to the evolving theory (Strauss & Corbin, 1990). This enables maximal variation on the themes emerging during the study. Thorne et al. (2004) suggested that studies using this approach build upon relatively small samples. The authors did not recommend minimum or maximum sample sizes, however, to date, studies using interpretive description, the sample sizes ranged from 8 (Gillespie, 2002; Elmberger, Bolund & Lutzen, 2002) to 38 (Thorne, Harris, Mahoney, Con & McGuinness, 2004).

Data sources and Data analysis

Thorne et al. (1997) encouraged the use of various data sources to broaden theoretical scope and provide insights into the developing themes (e.g., interviews, observations, lay print material, case reports and clinical papers). In contrast to traditional methodologies, interpretive description does not have a specific set of predetermined analytic techniques that must be followed at all times. However, Thorne et al. (1997) recommended using techniques that "encourage repeated immersion in the data prior to beginning coding, classifying, or creating linkages" (p175) such as those developed by Giorgi (1985), Knafl and Webster (1988), or Lincoln and Guba (1985). They argued that interpretive description requires researchers to become "intimately" familiar with individual cases and to "abstract relevant common themes from within these individual cases, and produce a species of knowledge that will itself be applied back to the individual cases" (p. 175). A key action when analyzing data is to make the research process as transparent as possible, which allows readers to assess transparency and accuracy of the findings.

Challenges to Using Interpretive Description

There are several challenges to using interpretive description. As interpretive description is a newer approach, there is a shortage of researchers prepared in this methodology. Along with this comes a limited number of published research and discussion regarding this approach. The lack of general awareness regarding this approach may increase the difficulty in obtaining research funding. The strongest critique according to Thorne comes from those who genuinely feel that departure

from the original methods creates bits of knowledge that do not ultimately contribute to some larger social (i.e., social science) theorizing. (S. Thorne, personal communication, October 26, 2005).

Rationale for Chosen Methodology

When topics related to occupational therapists' experiences of working with older adults are presented in the literature, the majority of the writing is anecdotal. These anecdotes are suggested by the authors without conferring with individuals working in the clinical setting or are extrapolated from other professions. For example in Kiernat's (1991) chapter titled 'Rewards and challenges of working with older adults' she discussed the benefits of and barriers to working with older adults, including a statement that gerontological occupational therapists confront ageism at work. While these may be valid issues, it is not known whether these issues were actually expressed by occupational therapists or generated by authors based on their own experiences. Explanations must evolve from the individuals who are immersed in the situation; otherwise research findings are divorced from the perceptions of those who have actually experienced it.

Cohen and Omery (1994) argued that we take so much for granted that we often fail to notice what is common in our lives. To really see what surrounds us requires an interpretive descriptive approach. Such an inquiry was appropriate for this study because the purpose of this research was to understand the experiences of working with older adults. I wanted to learn about the central underlying

meaning of this experience. The purpose was not to focus on the cultural behaviour and customs of this group, as is appropriate for ethnographic studies. Nor was the purpose to examine the process of becoming a gerontological occupational therapist and develop a theory, which would indicate a grounded theory approach. Nor was the purpose to solely examine the lived experiences, omitting external preconceived concepts and knowledge and explanations of the meaning to something, as commonly found in phenomenological studies. While these other focuses are important, it was beyond the scope of this dissertation to comprehensively examine these facets of gerontological occupational therapy.

In addition to being the most appropriate approach for this study, an interpretive descriptive approach is complimentary to occupational therapy's humanistic and client-centered philosophy. Both domains, interpretive description and occupational therapy, emphasize understanding the person as a core value (Mattingly, 1994). They also share the holistic view that "individuals need to be understood as a whole person within a particular situation, not separated from the environments in which they function" (Kelly, 1996; p.238).

Based on this review, the interpretive description tradition was selected to describe and interpret the experiences of gerontological occupational therapists. This approach helps us to understand how gerontological occupational therapists interpret their work and make meaning of what they experience.

CHAPTER THREE: PROCEDURES

Role of a Researcher

When performing qualitative research, one must demonstrate an awareness of personal biographies, assumptions and values, and provide a context in which the analysis and interpretation of the data can be understood (Ahern, 1999). This introspection is called *reflexivity.* Qualitative researchers advocate reflexivity as one approach to acknowledging the subjectivity intrinsic in the research process. Reflexivity should be viewed as a continuing, dynamic and subjective self-awareness (Finlay, 2002).

Particularly in qualitative research, it is imperative for the researcher to identify these personal views and biases at the outset of the study. This assists readers to understand my reality, as each individual's reality is unique. This disclosure was not comprehensive and only represents experiences that I perceived, at the time, to be the most influential. Explaining one's position about any aspect of life with any sort of completeness is never an easy task. This is partly because positions are not arrived at easily, nor is the task of explaining where I stand a simple matter of compiling all the components of my thinking and committing them to paper. The task was undertaken, however, to enable the reader to understand my inherent biases about humanity, research and occupational therapy.

In terms of my epistemological position, or how it is possible to find out about the world, it was my belief that the historical context was largely one based on

quantitative research emphasizing positivist values. My epistemological stance was one supporting interpretivism. Interpretivism argues that the researcher and the social world have an impact on each other. There is no neutral vantage point from which to reveal the world. Facts and values are not seen as distinct from one another and thus findings are inevitably influenced by the researcher's perspective and values, thus making it impossible to conduct objective, value free research, although the researcher can declare and be transparent about his or her assumptions (Snape & Spencer, 2003). According to Bruner (1986) we can never truly understand others' experiences, the best we can do is interpret them. The interpretivist stance emphasizes the importance of understanding people's perspectives in the context of their lives and thus natural sciences are not appropriate for studying human's experiences because the social world is not governed by law-like regularities but influenced by the context of the conditions and circumstances surrounding each individual.

My perceptions of working with older adults were shaped by my personal experiences. My educational background was in gerontology, sociology and occupational therapy, which in part explained my broad research question. I believed that adhering to one particular discipline would narrow my scope of understanding. Upon completion of my undergraduate degrees, I worked as a sole charge occupational therapist in a 330-bed long-term care facility in Ottawa. I believed that these experiences with gerontological issues enhanced my awareness, sensitivity and knowledge to the many challenges, decisions and

issues that occupational therapists face when working with older adults. I brought to this study knowledge of the societal level issues (e.g., attitudes towards seniors, current health care situation, rehabilitation ideologies, elder abuse) and the individual level issues (e.g., workload, multiple roles, assessment tools). My occupational therapy background complimented the qualitative approach used as they both took a holistic approach. Creswell (2003) suggested that close connection between the researcher and participants can compromise the researcher's ability to disclose information and can raise difficult power issues. This was not a major issue because I had not worked clinically in Edmonton and thus had no strong personal ties to any of the participants.

Due to the common work experience I shared with participants of the study, I brought certain biases and assumptions to this study. I filtered my data through a personal lens that was situated in a specific socio-political and historical moment. I believed that the experience of being a gerontological occupational therapist was a phenomenon in itself; that there were some common experiences shared by these individuals. I believed that occupational therapists are effective in maximising the quality of life and occupational performances of the seniors with whom they work. I believed that seniors have the right to access occupational therapy. I believed occupational therapists working with this population are as diverse as the people with whom they work. I believed that gerontological occupational therapy needs to be a specialty, providing further training to ensure that therapists are prepared to work with this population. I entered into the study

with the belief that ageism existed within occupational therapy practice. I perceived occupational therapists who work with seniors were at times, viewed by others as working in a less revered area compared to working in other areas (e.g., paediatrics and spinal cord rehabilitation). I needed to be cautious to not assume participants and I shared similar views and language describing work with older adults.

An assumption of this study was that the participants in this investigation were experts in understanding their lives as occupational therapists. The phenomenon of working with older adults could, therefore, be understood better from their perspective. It was further assumed that participants were able to articulate and communicate beliefs and meanings created in this world when asked to do so.

The activity of making my personal biases and views explicit allowed me to know myself better and, from the standpoint of becoming a researcher, contributed to the soundness of the research. The research was undoubtedly influenced by my own experiences as a gerontological occupational therapist. Rather than ignoring this influence, I recognized and addressed it which enabled me to use the added insight that comes from having worked in this position.

Personal Reflections as the Researcher

An important part of conducting qualitative research pertains to the role of the researcher. I highlight changes I experienced as I completed my doctoral research. First my understanding of qualitative research has broadened immeasurably. I have learned that qualitative research is much more than following a set of outlined procedures. It is an attitude, a belief, related to how one approaches research and views research topics, data, analyses and the writing process. I learned that the experience of being a gerontological occupational therapist, in all its multiplicity, along with its rewards and challenges, escapes being completely defined. Various parts of this experience are presented in this document in the form of important themes, but I do not claim to present the entire picture. I have also come to appreciate deeply that multiple minds and perspectives can improve the quality of my work. In talking with committee members, qualitative methodological experts, and even people external to the research, I learned that each one can share a perspective that can enhance, and sometimes redirect my own thinking and ideas.

I also learned a lot about myself. Several excerpts taken from my memos reflect my personal learning experiences.

> *Regarding Interview skills- It's funny. When I worked as an occupational therapist, I performed interviews all the time. Of course I tried to examine my skills critically and improve on my interviewing*

techniques. But now- I have hard evidence of what I am doing right as well as what I am doing wrong. Not only do I get to hear myself as I replay the tape, but I get to read, re read and re read again all of my words. Sometimes I groan as I read the transcript and think to myself... Did I really say that? Why didn't I say this? And THAT question... what a stupid question. It sure lets me evaluate and re-evaluate my interviewing skills. I think I can liken this procedure to standing naked in front of a 360 degree mirror with bright fluorescent lights all around me. What fun. What joy.

Regarding time- I have learned that the more time one has to complete something the longer it takes to complete. I definitely recommend that if you are only working part time on your studies- you need to book specific days on which to work. I tried early on to just fit in 'doing my research' here and there.... But something always came up and my work got put to the side. I now have 2 days blocked off and I try and keep it that way ....well most of the time....

- May 27, 2005

Performing research is not one smooth uninterrupted linear process. A challenge to this whole research study is that I have had 2 children since the initial development of my research proposal.

The challenges to this are:

1) If Murphy's Law says that it takes 3x as long to get something done as planned.... Try throwing two births into the equation...

2) I have had two significant breaks in the research process. After Emma I stopped all work for 6 months, taught a course from 6-12months post partum. I finally got back to my research 1 year after Emma. After Katie was born I took a 9 month hiatus. I have been back at work now for about 6 weeks. It is only this week that I feel like I am moving forward. This past month and a bit I have just been trying to re-immerse myself in the project and determine where I left off.

3) And finally probably the most important factor- I never anticipated how having children changes your world in SUCH a significant manner. All of a sudden my being a mom was the most important role in my life. Whereas, prior to the birth of Emma, probably the largest part of my identity was that I was a grad student in the Faculty of Rehab Med at Corbett Hall. Now that title seems to have been bumped down the ranks to about 4th or 5th in significance.

- February 14, 2005

I also learned that the process of performing research can be daunting.

I have coded all five interviews completed so far. I now can analyze the data that I have gathered. However, I am at a standstill. Now

what? I try to find other things to do. Go downstairs to eat. Go for a walk. Clean up the house. It is somewhat intimidating to move to the next step. I am reading the literature for suggestions as to how to go about it. It seems so daunting. Where to start first? Dickie (2003) described something similar. She said that "being in the field and then distancing myself, being in the data and then leaving them" (p53). She too talks of the need to go for a walk, do chores or read the latest journal. Maybe the baby will come early and then I can have a big distancing of my interviews...for months and months.....nah...this is just an excuse... there is a lot of work I need to do before this second baby comes.

- December 1, 2003

Looking beyond the challenges of research, I also saw the rewards of performing research. As I often re-immersed myself in my data, I realized that my research question remained really important and that it was important for the work to be done. I also learned that my understanding of the experiences of gerontological occupational therapy was enhanced in an environment of reflective dialogue. I learned that using methods within the qualitative tradition provided an opportunity for therapists to reflect on, question and construct their experiences as gerontological occupational therapists. Several participants commented on how the dialogue enabled them to reflect on their practice, stating that they rarely made

time to do this. I was surprised by the reactions of the participants when they shared their stories, as evidenced by an excerpt of my personal reflections.

> *It seems to me that when therapists talk about a time when they felt dissatisfied (often referring to the example they put on their written statements), they get emotional. Their voice quivers, they get more fidgety, even a few have had tears in their eyes. This 'failure' as they say seems to sit with them... sometimes a long time. These are human beings who are in this profession to help. It seems to pain them when they are unable to help.*
>
> *-June 6, 2005*

This study revealed the importance for therapists to reflect on the meanings of their working experiences with older adults. It also demonstrated the difficulty and complexity integral to working with this population, which sometimes lead to the sharing of raw emotions. I have learned that this depth is only possible through the use of qualitative methodology. At the outset of my doctoral research, I proposed to conduct a quantitative research study. As I refined my research question, I then turned my attention to the qualitative approach realizing that I was looking into a phenomenon that needed to be examined in greater detail and where little research existed. I then considered using grounded theory and later, phenomenology. After reading a wide array of approaches and meeting with qualitative experts, I honed in on my final and most suitable approach,

interpretive description. One of the entries from my memos demonstrated my sentiments of this process.

> *While it has been frustrating at times (this is an understatement) to rethink my approach (i.e., I went from quantitative to qualitative and then almost every main stream qualitative approach prior to deciding upon the one I have chosen); with each change in my proposal I felt like I was getting closer and closer to what it is that I was truly hoping to capture in my research.*
>
> *-May 27, 2005*

As Thorne articulated, interpretive description is a qualitative approach that has the benefits of the other traditional approaches but does not have "to pretend to be the full meal deal" (S. Thorne, personal communication, October 26, 2005). Interpretive description was appropriate for this health-related research as it did not require that the epistemological claims typically associated with traditional approaches be accepted fully, as well it permitted an interpretive twist regarding a shared phenomenon from the perspective of those who live it. Regarding the interpretations that I made, I adhered as closely as possible to my participants' accounts, but acknowledged that deeper insights were obtained by synthesizing, interlocking and comparing the accounts of a number of respondents. The interpretations were grounded in the accounts of the participants, but employed language, conceptualization and categorization that was not their own. Thus, the

generic strategy of interpretive description appeared to be the most congruent qualitative approach for this research study.

My research was just one discourse examining the experiences of older adults. I, as the researcher, along with the participants came together in a shared space and a shared dialogue. As Arthur Frank stated, "No one voice is ever his or her own. Each voice is permeated with others" (personal communication, February 19th, 2005). It is my hope that this shared voice will have an impact on readers and will validate feelings experienced by other occupational therapists who work with older adults. It is my desire that the findings from this research will encourage personal and professional reflections.

Data Collection Procedures

Introduction

Hearing one person's story regarding an experience is inadequate in describing the fullness of the experience. Van Manen (1997) argued that it is only through the collection of multiple voices that we can access experience. This study used responses to written scenarios and in-depth face-to-face interviews to gather stories of occupational therapists working with older adults.

Participants

Using purposive sampling, I initially identified ten participants who worked primarily with older adults. Purposive sampling is a type of non-probability

sampling method in which the researcher selects participants for the study based on their characteristics (Morse & Richards, 2002). The goal of purposive sampling is to maximize the researchers' understanding of the phenomenon and thus generalizability is not a guiding criterion (Erlandson, Harris, Skipper & Allen, 1994). Instead, a wide variety of respondents is optimal to discover the meaning and to uncover the multiple realities which exist. This selection helps to ensure that the findings are comprehensive, complete, saturated, and account for negative cases (Morse, 1999). Any common patterns that emerge from this variation are important in order to capture the core experiences of working with older adults. Within this purposeful sampling strategy the specific technique of theoretical sampling was used to recruit the final six participants. As the themes and concepts evolved, participants were chosen based on their ability to contribute to the developing theories. The final six participants targeted were males, those who worked in rural and small urban settings, home care, rehabilitation settings, and occupational therapists who were older then 45 years. In total, 16 participants shared their experiences related to working with older adults. The final number of participants was determined when no new categories emerged and the relationships between data in existing categories were clear (Morse & Singleton, 2001) and concepts and themes repeated themselves in at least several situations (Morse & Richards, 2002).

Participant Selection for In-depth Interviews

The inclusion criteria for purposive sampling were occupational therapists who

a) lived within a one hour drive of Edmonton;

b) reflected a range of work settings; and

c) defined themselves as working primarily with seniors for a minimum of two years, with a minimum of 20 hours a week, to ensure adequate time in experiencing working with this population to describe their lived experiences. While the term 'primarily' is a relative term, I established a minimum cut-off point for participants to have an estimated caseload of at least 60% adults over the age of 65 years. The 'two year minimum' was a criteria selected based on Benner's (1984) novice to expert model which proposed that an individual who worked in the same or similar situations for two to three years is deemed competent. This individual has a sense of mastery and can identify aspects of a situation which can be considered most important and differentiate him or her from those who can be ignored. The '20 hour work week' minimum was selected as it represented at least 50% of a typical work week and helped to ensure that individuals were immersed in their work and the situation of interest. In addition, the Canadian Federal Labour Standard Review considers work weeks of less than 20 hours to be part-time work (Canadian Federal Labour Standard Review, n.d.).

In order to ensure people with diverse viewpoints were represented in the sample, a deliberate attempt was made to include people with different characteristics. The following is an outline of features that was used to guide participant selection based on characteristics provided by the national association (CAOT, 2005a). In

order to enhance the diversity in narratives, a minimum of two individuals for each characteristic was sought.

Work setting

acute care

rehabilitation centres,

long term care centres

specialized seniors' programs (e.g., community programs for seniors)

home care.

Geographic location of work

metro

urban

rural

The geographic locations were divided based on the 'geographic locations' definitions of Statistics Canada (2002) definition as well as the characteristics of health services available in each region. 'Metro' was based upon Statistics Canada's definition of Census Metropolitan Areas (CMA) - a large urban core of 100,000 or over. 'Urban' was based upon Statistics Canada's definition of Census Agglomerations (CA) has an urban core of 10,000 to 99,999. 'Rural' was based upon Statistics Canada's rural and small town definition, thus this population lived outside the commuting zones of larger urban centres-specifically, outside Census

Metropolitan Areas (CMAs) and Census Agglomerations (CAs). Metro included regions that had specialized referral centres. Urban included hospitals that accepted referral cases from other regions. Rural included all other regions.

Ages

< 35

35-44

45 >

Other work experience

Participants who worked in other settings prior to working with seniors were particularly sought. This enabled a comparison of gerontological experiences with other specialty areas (e.g., paediatrics, mental health, spinal cord injuries).

The exclusion criteria were

a) Individuals who were administrators, professors, and researchers.

b) Individuals who worked less than 20 hours a week.

Participant Recruitment for In-depth Interviews

Participants were recruited in various ways. At the outset of the study, members of the Alberta Association for Registered Occupational Therapists who indicated they worked in geriatrics, worked in Edmonton or surrounding area, and agreed to

have their names and contact information given to third parties were mailed the recruitment notice. This enabled potential participants to volunteer themselves. From this recruitment approach I obtained nine replies of which seven were eligible. One excluded individual had less than two years experience and the other had only a 40% case load of seniors.

As further participants were required, I asked my contacts at the university as well as managers who worked in various facilities in the area of aging to recommend occupational therapists working in specific settings (e.g., acute care, long term care) who would be useful to interview. A 'useful' participant was one who had the potential to provide the required information, was willing to reflect on the phenomena of interest, and had time to participate (Morse & Richards, 2002). I asked my colleagues to provide potential subjects with the recruitment notice along with my phone number and email address so that they could contact me if they were interested in finding out further information regarding the study. From these sources, an additional seven participants were included in the study.

I acquired two more participants through the use of the CAOT Networker. This is a database of CAOT members who agreed to have their names and contact numbers included to network with other occupational therapists within Canada. This amounted to 16 participants for the study.

Each occupational therapist that showed interest in taking part in the study was contacted by telephone and given a more in-depth explanation of the study. When they agreed to participate, I screened them to ensure that they met the inclusion criteria of the study. After the screening, a date and a time for the interview was set. An information sheet was sent to participants via electronic mail or fax, depending on their preference (Appendix A). Along with this information sheet, a scenario sheet with two focused questions was sent to them to complete at their leisure, prior to the interview (Appendix B). These focused questions enabled participants to provide descriptions of specific incidents, both positive and negative, which they perceived as significant to the purpose of the study. This question sheet provided the opportunity for participants to express themselves in writing, enhancing the depth of data gathered and allowing for data source triangulation.

Procedure for Interviews

One in-depth semi-structured interview was performed with each of the 16 participants. Each interview was audio-taped and ranged in length from 50 to 90 minutes. Conversations were transcribed by a hired transcriptionist within a couple of days of each interview. Interviews were completed between October 2003 and June 2005.

Interviews were held at a location convenient to each respondent (e.g., their work place or home). I began the interview by reviewing the information sheet and after

participants signed an informed consent form (Appendix C). I informed participants that it was important to hear about working with seniors from their point of view and that I was there to learn from them. In order to describe the participants, demographic information was collected on age, gender, geographic setting, work setting, whether or not they had prior experiences working with other populations and years of clinical experience working in the profession. I then invited participants to relate personal narratives regarding their experiences of working with older adults. I used an interview guide to provide an element of consistency in the interviews (Patton, 2002) (Appendix D). Each interview covered the same general themes, but was flexible enough to encourage participants to raise topics of particular interest to them. Such topics were then incorporated into subsequent interviews with other participants. Clarification was sought to enrich the description and illuminate the experience.

After my initial interview for the final six participants, I presented themes and categories that I had found from the earlier interviews. I asked these subsequent participants to share their comments on my initial themes and categories. I used verification questions such as 'some people say.... is that right for you?' When their ideas differed, I encouraged them to elaborate. By listening to the comments of the later participants, I was able to modify, rework and expand on my earlier conceptual framework.

I continued interviewing until I saw consistent replication of themes and concepts within the stories that participants shared. I performed a follow-up call or email to thank participants and ask if the interview raised any new issues. One interview with each participant was adequate in obtaining a rich description. However, I offered each respondent the opportunity to share further ideas regarding their experiences in a subsequent interview, phone call or email. However, no participants acted on this invitation.

Participant Characteristics

The sample comprised of 14 women and 2 men. Six of the participants were under 35, eight were between the ages of 35-44 and two were older than 44 years of age. There was a broad range of work experience. Together, they had a combined total of more than 190 years of experience working as occupational therapists. The average number of years participants had worked for was almost 12 years. Three participants had just under 3 years experience, while seven participants had 15 years or more. Two occupational therapists had 28 years experience. Ten participants had work experience with populations other than older adults. Two participants worked in rural settings, while two others worked in small urban centres. The remaining 12 participants worked in a metropolitan center. Work settings included acute care, rehabilitation and sub/acute units, home care, long term care (LTC) facilities and specialized seniors programs. The majority of the participants completed their occupational therapy training at the

University of Alberta. Further details about the participants can be found in Appendix E.

Data Analysis Procedures

This study had an emergent research design, which means data collection and data analysis were simultaneous and ongoing hypotheses were tested as they arose within the data collection process. This analytic approach takes advantage of periods of immersion in the data as well as periods of strategic withdrawal in which a more reflective analytic process is made possible.

As mentioned, in contrast to traditional methodologies, interpretive description does not have a specific set of predetermined analytic techniques that must be followed at all times. Thorne et al. (1997) suggested choosing techniques that best suit the study in question. The interviews as well as the written responses to the focused questions were analyzed using Glaser and Strauss' (1967) process of constant comparative analysis. This type of analysis involves a continuous comparison between the data and generates categories and hypotheses about the phenomenon of interest (Glaser & Strauss, 1967). It looks for both similarities and differences and identifies negative cases (also known as exceptions), which demand that the researcher account for the determining conditions (Strauss & Corbin, 1990). By using this approach, I identified patterns in the experiences of occupational therapists working with older adults and compared variations within cases and across cases. I also grouped cases according to key variables selected

and made comparisons across those groups of cases. For example, I compared occupational therapists in different settings and with ranges of experience. Categories and themes were generated and ongoing hypotheses were tested as they evolved from the analysis process (Glaser & Strauss, 1967).

My first step in coding the data was to take the first five transcripts and read each interview in its entirety to get a sense of the entire story and the 'whole person'. The data were then sorted to identify patterns or clusters of codes. At that point, I used as many codes as possible to enhance adequate coverage. Codes that emerged were ones such as 'complex care', 'slower pace', 'less demanding', 'inadequate human resources'. I reread each interview and its codes to make sure that coding decisions were consistent. After every five interviews, I printed out each code (e.g., slower pace) with all relevant excerpts from each participant. This enabled me to re-evaluate whether I was being consistent with my coding over time with new participants. I frequently returned to typed transcripts to reread a phrase or statement for the purpose of validating coding decisions. The interviews following the first five were then read in their entirety and coded individually. New codes were added as they emerged from the interviews. I then sorted codes to form categories from which I developed themes. For this process, I developed a document outlining the different categories (e.g., health, life stage, current cohort, work conditions, etc.) and the larger encompassing themes (i.e., client characteristics, environmental influences). As data within each category were compared and contrasted, new categories emerged and some categories were

combined. Comparing and contrasting the different categories enabled me to ensure that they were mutually exclusive. I established linkages between and among categories throughout the process of data analysis, and these provided a conceptual order for the developing categories. Discussion with the six final participants, along with members of my doctoral thesis committee facilitated the fine tuning of a conceptual framework. Figure 1 provides an example of emerging codes, categories and themes.

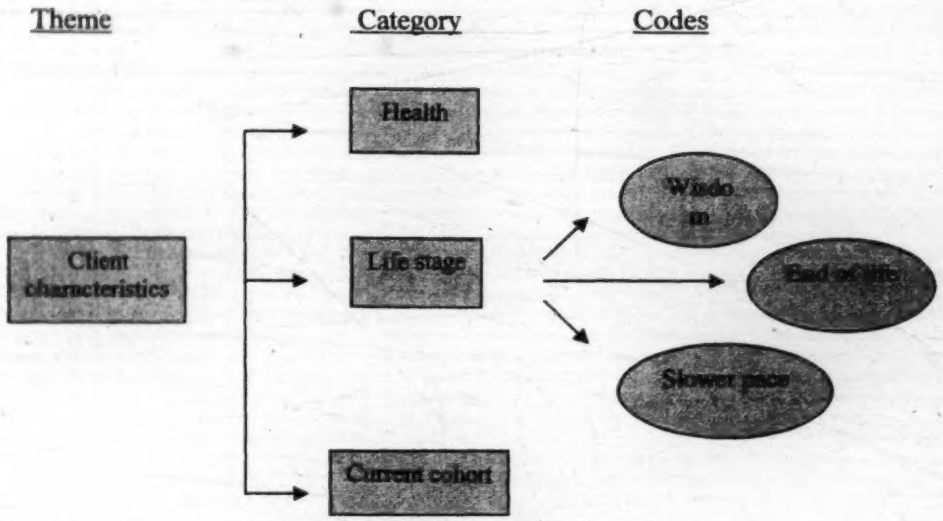


Figure 1: Example of a theme with its categories and codes.

As recommended by Thorne et al. (2004), the key part to the interpretation is not coding, sorting and organizing of the data. It is the process of intellectual inquiry. I continually asked myself, 'What is happening here? Why is this here? Why not something else? And what does it mean?' One of the premises of interpretive description is that findings do not 'emerge' in the sense of having their own agency, nor does the data 'speak for itself' (Thorne et al, 2004). It is the researcher who is active in the research process and who ultimately determines what constitutes data. It is one's own interpretation that is provided as only selected data is deemed important, and thus it is the researcher who is the interpreter of the data (Thorne et al., 2004).

Data were entered into NUD*IST Vivo (Qualitative Solutions and Research, 1997), a textual database computer software program which can graphically represent relationships among codes. It is important to note that the software provides tools to help with analysis, but it can not do the analysis for the researcher (Weitzman, 2000). However, compared to exclusively using a manual system for data analysis, Morse and Richards (2002) proposed that qualitative software programs offer an increase in the web of ideas that the data produce. In addition, qualitative software programs allow researchers to manage ideas with increased ease by storing them, defining them, and accessing them.

Criteria for Rigour

In order to demonstrate that the research findings are justifiable and valuable, qualitative researchers must demonstrate rigour (Morse, 1991). Rigour can be achieved in qualitative research by rendering visible the research process through reflection and reflexivity (Davies & Dodd, 2002).

To enhance rigour, the following strategies were employed

1) I acknowledged and assessed the influence of my own background as a therapist who has practiced with older adults on the gathering and analysis of the narrative data. My beliefs and biases were outlined in the 'Role of the Researcher'. The bracketing process in this study began as the research study was formulated. I wrote down potential biases I held regarding the phenomenon of working with older adults. I kept a written log of further

biases that were identified during the research process. Throughout my data analysis, I referred back to the written log in an effort to decrease the possibility that potential biases influenced the extraction of essential themes.

2) During the interview, probing questions were used to clarify meaning to assess congruency with participant's intended meaning.

3) I actively sought out contrasts, comparisons, and extreme cases (Huberman & Miles, 1994). Participants' experiences took place in various work settings (e.g., acute care, home care, long term care facilities, etc.). That the participants reported similar experiences provides more credibility to the findings.

4) The trustworthiness of the findings was strengthened by the triangulation of data sources (i.e., use of interview and written responses to focused questions) (Patton, 2002).

5) Memoing was used. Memoing is a tool used in data analysis, where the researcher has extensive notes reflecting evolving thoughts on code meanings, theoretical ideas and preliminary conclusions. Memoing can bee seen as contributing to rigour because it is analytical in itself and because it contains immediate and later perceptions and thought about the participants (Rose and Webb, 1998).

6) I presented interpretations to members of the population being studied and asked for their feedback. This member checking was done in the form of interviews for the final six participants. One purpose of member checking

is to realign the balance of power in the research relationship as I am making a deliberate attempt to avoid misinterpretation. While Lincoln and Guba (1985) suggested incorporating member checks into interpretive inquiry design, Schwandt (1997) proposed that "it is not entirely clear how the procedure actually helps establish the truth of the findings" (p.88). He argued that member checking is "not profitably viewed as an act of either validation or refutation but simply another way to generate data and insight" (p.89). Cohn and Lyons (2003) argued against using member checks as they believed researchers bring an interpretation to the analysis that is informed by theoretical concepts that participants may not know or understand. Thus, they may be unable to comment on an interpretation that is at a conceptual level. Regardless, member checking provided further insight into the essence of the phenomenon of working with older adults. I felt strongly that the concepts I developed should be understood by the therapists themselves or my work would be futile. It was my belief that the ability of other therapists who work with older adults to access and relate to my findings enhanced the credibility of my research.

7) Findings were conveyed using rich, thick description. As Creswell (2003) suggested, this enables readers to understand the setting and gives the discussion an element of shared experience.

8) An audit trail was conducted throughout my data analysis. The audit trail is a careful documentation of how I conceptualised and categorised the data collected. The importance of an audit trail lies in the ability of

interested parties to reconstruct the process by which I arrived at my conclusion.

9) An investigator with advanced experience in qualitative inquiry reviewed my research question, method, and resultant themes. This is known as peer checking (Lincoln & Guba, 1985).

10) Another peer check was completed by investigators with advanced knowledge in gerontological issues within occupational therapy, who reviewed the analysis and discussion and verified that the findings reflected their experience.

11) I made use of my colleagues. I discussed the data and findings with my thesis committee. I also shared the experiences with fellow graduate students. Once again, this was another form of peer check.

"Rigor is less about the adherence to the letter of rules and procedures than it is about fidelity to the spirit of qualitative work." (Sandelowski, 1993, p 2). It is my belief that the reader is ultimately the best test of the rigour and quality of the research. When readers can relate their own experiences with the findings, this indicates that there are commonalities amongst occupational therapists working with older adults. Emden and Sandelowski (1999) suggested that credibility of the findings occur when complexities are made visible through the analytic process and are articulated with an openness that acknowledges certain tentativeness about the final research outcomes. I incorporated these ideas when formulating my discussion. Combining all of the above steps helped enhance rigour.

Narrative Structure

As this was a naturalistic study, results were presented in a descriptive, narrative form rather than as a scientific report, as found in quantitative studies. This study is reported in the first person to indicate that as the researcher, I am not merely a neutral observer but an integral part of the generation of knowledge. In order to accurately portray participants' perceptions, I intertwined actual quotes of participants with my interpretations. I used indentations in my written work to call attention to the quotations included. The narrative outcomes and interpretations were compared with the current literature at the end of the study. This enabled an analysis of similarities, differences, and omissions in current published works.

Personal Significance

This study has personal significance for me. I have always been interested in the stories shared by the people that surround me, be it an older client, who shared with me the hardships she experiences with the nursing staff or a colleague, who shared with me her frustrations due to the 'political red tape' she faced at her work. These conversations usually took place when others were out of earshot. To me, this has been the key to entering their worlds and finding out about their lives and the issues that impacted their lives. My interest in pursuing this study was spurred by comments that were frequently made to me such as 'Good for you. *I* couldn't work with *old* people" and by fellow therapists working in the aging field confessing "- I *actually* like working in geriatrics." What is it that makes therapists feel the need to justify their enjoyment of working with older adults?

The latter comment is familiar to many health professionals and is referred to in the literature. Noonan (1992) reported that it is common for individuals who work in long term care to feel the need to apologise for their choice of work because of the belief that it is not as highly skilled or valued as that of their counterparts working in acute care settings.

Ethical considerations

The proposal for this research was approved by the Regional Health Research Ethics Board at the University of Alberta in September 2003. All potential participants were advised in writing that they were being invited to participate in a research study and that participation in the study was voluntary. Potential participants were assured that they could refuse to participate in the study. They were informed that their identities were confidential and the only foreseeable risk associated with this study was the small possibility that a participant may become emotional when sharing his or her experiences. This happened in a couple of instances. I listened and encouraged them to discuss their feelings with me.

To protect confidentiality of subjects, all direct identifying information was removed from the transcripts and pseudonyms were used. All tapes are stored in a locked cabinet at the University of Alberta. The tapes will be kept for five years after which they will be destroyed.

Summary

With an increasing aging population and given the anticipated increase in the number of gerontological occupational therapists, there is a need to better understand the experiences of therapists working with seniors. Interpretive description is ideal for this type of examination as it searches for an understanding of the experience. This approach moves beyond the description of an experience and enables interpretations about a shared phenomenon from the perspective of those who live it. An understanding of the experiences of gerontological occupational therapy can provide information relevant to working with seniors to help prepare occupational therapists for practice and progression within this area of practice.

CHAPTER FOUR: EXPLORING THE EXPERIENCES OF GERONTOLOGICAL OCCUPATIONAL THERAPISTS

Introduction

This study examined the experiences of occupational therapists working with older adults and identified shared aspects that emerged from participants' oral and written accounts. What is it like to work with older adults? Participants' accounts suggest that occupational therapists working with older adults have diverse experiences, knowledge and expertise. Despite the diversity, there are commonalities that unite occupational therapists who work with older adults.

Since this study examined perceptions of *individuals*, there were a wide variety of expressions and sentiments. Regarding the forthcoming categories, not all participants felt strongly about each of these categories. There were instances where two participants disagreed with the perspective that 14 others expressed. This demonstrated that there was a common perception of 'X' by the majority of participants but not by everyone, confirming these are general themes and categories that emerged from participants as a collective. In addition, when descriptions of older adults are discussed, it is essential to remember that not all older adults have each of these traits. On several occasions, participants made it explicit that some seniors have differing, even opposing traits from those discussed.

Although the primary focus of this study was the work experiences of the occupational therapists, I believed it was important to include information related to work experience. Therefore, the analysis will be described in the following manner: (a) becoming a gerontological occupational therapist, (b) experiences of occupational therapists, (c) attributes of a gerontological occupational therapist, (d) participants' advice for working with older adults, and (e) career plans. Pseudonyms were used to protect the identity of participants.

Becoming a Gerontological Occupational Therapist

The occupational therapists interviewed for this study did not have a consistent pattern for entering into the field of aging; however, two themes emerged from the interviews as to how they became gerontological occupational therapists. The first was what I call 'serendipity' or fell into the job. The majority of participants did not have a specific desire to work with older adults prior to doing so. The predominant sentiment was, 'I never expected to work with seniors, but I have come to love it.' Tanya shared her opinion on how her colleagues came to work with the older adult population.

> I think that a lot of them have jobs in that area because it's one of the biggest areas that needs to be served.... I think a lot of them ended up in jobs because that's what was available and people took employment, but ended up liking it. That's...the feedback I get more than anything from my classmates, is maybe, "I wasn't expecting to like it, but I do."

It appeared that participants ended up working with older adults because this was the area that provided job opportunities. Many participants commented that it was 'just by chance' that their first job was working with older adults, and it wasn't until after that exposure that they decided to stay. Jane, an experienced occupational therapist of 20 years, initially viewed her first position after graduation, a job working with older adults, as a transition job. However, after working there for a period of time, she decided to stay in that field. Another 20 year veteran, Alexandra, discussed how she was recruited by a seniors' center right after graduation. "It never occurred to me that I'd work with seniors; they called me." Some participants who 'fell into' this area, talked of having a positive experience with older adults during their clinical placements. They shared that their clinical placements increased their interest in working with this population. These placements also seemed to help prepare them and make them feel more comfortable with taking a position in a gerontological setting. A noteworthy minority of participants within this 'serendipitous' group remarked that upon graduation they were focused on working in the community, primarily home care. It was by happenstance that they worked with older adults within this setting but they each chose to remain working with this population.

The second manner of entering into the field of aging was that of being pre-meditated. Two participants, Tanya and Alison, knew that they wanted to work with older adults even prior to entering their occupational therapy education. Tanya said, 'I knew when I graduated I wanted to work with seniors; that's why I

went into OT, was to work in geriatrics." Interestingly, both occupational therapists spoke of having very close relationships with their grandparents, which in turn was a primary influence for their decision to work with older adults.

There was no indication that any of these occupational therapists worked in the field of aging because they felt sorry for older adults. Their comments reflected genuine regard for their clients, with a strong belief that older adults, even the very old, remain valuable members of society. Linnea, an occupational therapist who worked in the community, stated, "It's essential for the therapist to convey that 'Hey, you may be growing old, but you still have a lot to offer to society and to yourself and to the community'."

Experiences of Occupational Therapists Working with Older Adults

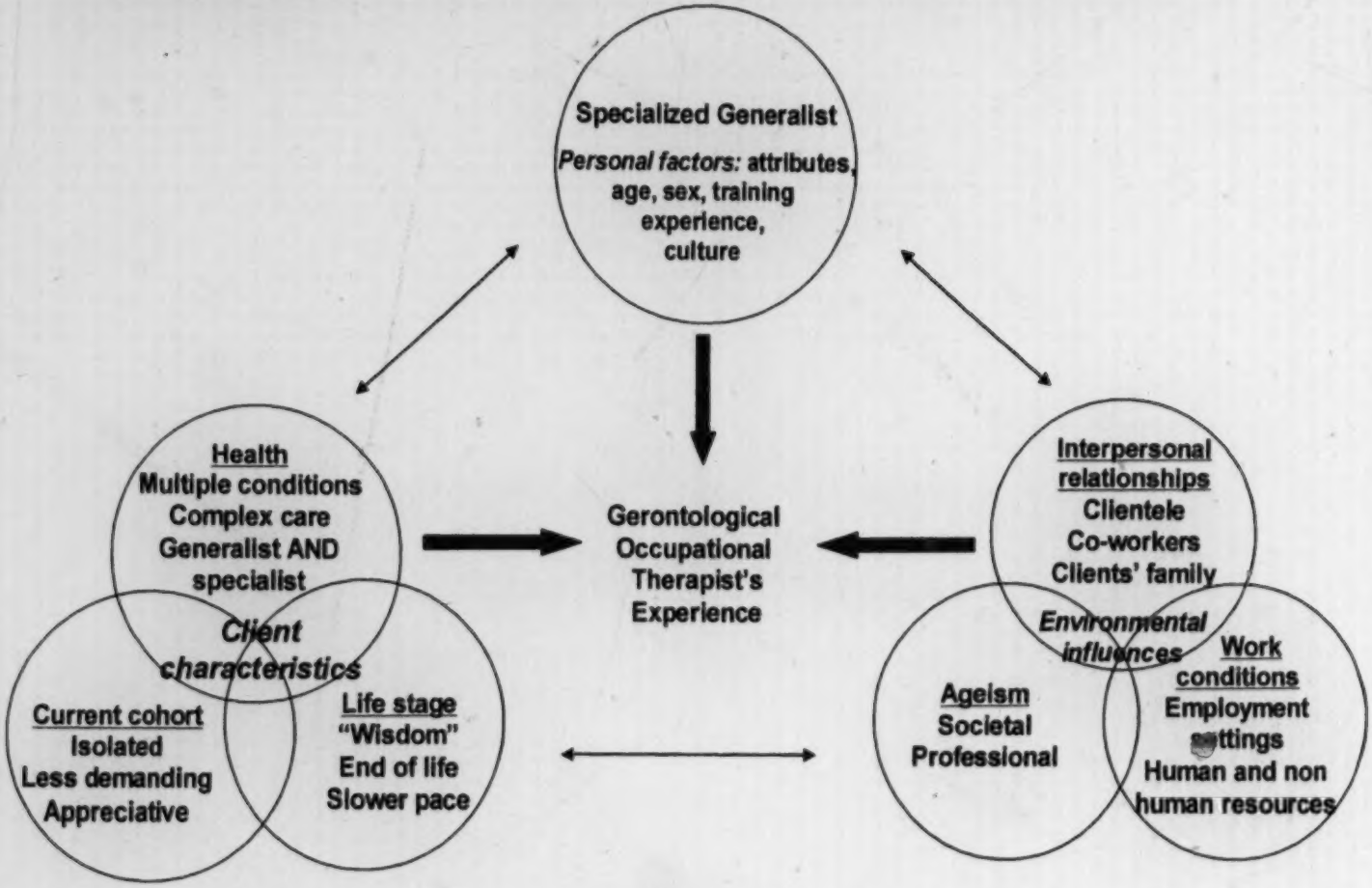
One could argue that knowledge of generic occupational therapy skills is enough when working with older adults. However, listening to participants, it was their perception that there were many unique aspects that were important to consider when working with this population. Focusing on the research question, 'What are the experiences of being a gerontological occupational therapist?' participants' stories revealed a wide range of accounts relating to their experiences of working with older adults.

Following the analysis of the interviews with the gerontological occupational therapists, a conceptual framework was developed reflecting participants'

experiences working with older adults (See Figure 2). Within this framework, the gerontological occupational therapist's experience is positioned centrally and is impacted by numerous factors: the occupational therapist, client characteristics, and environmental influences. The occupational therapist, depicted as the specialized generalist, comprises of several personal factors (e.g., attributes, age, sex, training experience and culture). Participants spoke of two themes influencing their practice: client characteristics and environmental influences. Each theme is at the centre of three concentric circles. Each circle depicts a major category (e.g., health, ageism) raised by participants, reflecting their accounts of working with older adults. The circles within each theme are interconnected, demonstrating the multiple interactions and influences within the client and environment.

The gerontological experience is not a static process. It is dynamic. The themes of client characteristics and environmental influences along with the occupational therapist each influence each other and require the therapist to adapt quickly to changing conditions. This framework can serve as a guide to assist the reader when reading the rest of the section titled 'Experiences of Occupational Therapists Working with Older Adults'.

Figure 2. Framework depicting the multiple factors influencing the experiences of gerontological occupational therapists.



I sought to discern the unique aspects of working with older adults by asking participants, who had worked with other populations, to comment on how their experiences with other populations differed from those with older adults. Interesting to note, two participants (one male and one female), in two different work settings, had an entirely different perspective regarding the uniqueness of working with older adults. When asked about their experiences of working with older adults, they responded that they did not consider themselves as "working in geriatrics" or with "older adults." This was despite the fact that at least 90% of their caseload consisted of seniors. They said that they preferred to look at each person individually.

> I never really looked at it and specifically said, "Yeah, I work with older adults." That's the population. It's a huge amount of my caseload. .... I don't know; it's just the population I have in here. I guess I want just to look at people as people. [Doug]

This perception had an impact on their interview comments. When asked about sentiments related specifically to older adults, they responded with comments akin to this one made by Julie

> I think it's more general, and you can see the same thing at any age; there are people that are appreciative, and there are people that are just expecting to have things done for them, and you're there to do your job. So it depends on the individual.

Sentiments about their Job

All participants expressed contentment with working with older adults. Participants talked about their experiences being rewarding. Linnea, who worked in the community facility enthusiastically remarked

> It's been a joy....I'm not just glorifying this position...or saying that it's better than other professions or other opportunities... but I think any student interested in working with seniors ... will find ...rewards, and ...be happy in this area.

There were plenty of positive aspects suggested by participants. While Linnea light heartedly exclaimed "I get presents; isn't that good!" several commented on the positive verbal feedback that their clients willingly provided. Other satisfying aspects included good salary, job security, diversity in personalities of clients, being an outlet for older adults' loneliness, and the reward of reintegrating older adults back into the community. Summer's comment reflected the sentiments of many participants when she characterized the older adults with whom she worked as having, "just terrific senses of humour. I don't think I've ever laughed so hard with a group of people." On a more philosophical level, Chris revealed that working with older adults

> helps you live your life like you need to....I have seen people here with a lot of regrets 'I should have done this, I should have done that.' So I don't want to live that way... I don't want to be looking back in retrospect and saying, 'Maybe I should have traveled to Africa,' or, 'Maybe I should have done something else.'

In Appendix F, narratives are shared that illustrate inspiring stories related to older clients that not only impacted the clients themselves but has also impacted the occupational therapist working with them.

Not every occupational therapist was entirely positive. Along with the rewarding experiences of working with this population, came challenges. As Carla who worked in a rehabilitation hospital revealed about her experiences, "It's heartbreaking, but it's rewarding." Ana who worked in a psychiatric facility talked of her personal struggle.

> I'm looking for a change ... because it's hard [on me] to always see decline and deterioration, and with older adults; you see that a lot. Sometimes it's really difficult, because from a rehab perspective, you want to see change [improvement].

Overall, participants expressed a strong sentiment of satisfaction when working with seniors and appeared passionate about their jobs. So much so, that in a couple of instances participants expressed emotion. Their eyes teared up and their voices quivered while expressing sentiments about their jobs. Even Ana, who talked of leaving her work setting and perhaps this population, expressed her enjoyment and satisfaction of working with older adults.

Client Characteristics

1) Health

Within the category of health, there were three interrelated sub-categories: multiple

conditions, complex care, and generalist versus specialist.

Multiple conditions. Therapists spoke of older adults' increased likelihood of having multiple conditions that were not part of practice with other age groups. As two therapists explained

> It's not like working with an adult with a burn or an adult in orthopaedics. Geriatrics, most of our patients, well, all of them generally… have more than one diagnosis, so you're not just dealing with one thing; you're dealing with ten things and how they affect each other….you're looking at a whole gamut of issues here. Sometimes and actually, most often you can't pinpoint what it is with the geriatric population. They've got physical issues, they've got mental issues, medication… polypharmacy is a huge issue with the senior population, too. [Brittney]

> I worked in kind of an out-patient clinic setting, and worked with just adults in general, or we sometimes had teenagers or young adults, I think that was a little bit easier, because you weren't dealing with as many diagnoses …it was a place where we did orthotics… so it was like there was only one problem, and you didn't see all … the other problems…. Sometimes I'll have an older adult with five or six or whatever diagnoses, which could be physical or psychological. So you're dealing with so many things all at one time with that one person. [Ana]

Christina's comment supported this notion. "It's easier if you work in acute and ortho, you just have to focus on that, whereas the elderly, they might have had a fractured hip and dementia and Parkinson's."

In addition to the multiple health issues, many of the older adults' conditions were chronic. As well, their illnesses often presented atypically. Participants talked of the challenges of determining the source of a symptom with older clients. As Christina compared, "A younger person … it might be more obvious what a symptom is caused from, than if all the systems are going when they're a bit older, it might be a bit more difficult to figure it out." She expanded

> If they're confused, why are they confused? Is it… a sudden change, is it a bladder infection, or have they had a stroke, or have they taken too many pills that can be really hard to figure out. So what do you do in that case? Do you send them off to the doctor, or do you try to problem-solve on your own. And it's hard… to find out how you're going to help.

Compared to younger populations, participants expressed that older adults were more likely to become seriously ill and more likely to experience rapid declines in their condition. After their decline, participants talked of the slower pace for recovery from illness compared to the younger population. As Summer put it matter-of-factly, "They are aging and there's some things that just aren't going to improve. So you need to be okay with that…. You're not going to institute this therapy… and in 6 months, they're going to be back to a fully independent, functioning individual without problems… You

are dealing with people who are moving towards the end of their life, and they're not going to always get wonderfully better" and as Emma articulated, "decline for most people is inevitable."

Complex care. With the increased likelihood of multiple health conditions combined with the chronicity and atypical presentation, a central feature inherent in the experiences of working with seniors was the complexity of care. Older adults were seen as more medically challenging to care for than their younger counterparts. As Hanna in home care stated, "Medical complexity- I just think that's the nature of the beast; that's the cost of doing business." Summer explained

> The needs are different, how they respond to things are different, the fatigue is different, how medication works in older people is different.... I mean, a person can be on medication that they've been on for 40 years; that doesn't mean that it's working the same way for them any more, 'cause they're metabolizing it different....it's not the same as just an adult who's older; there are really different things.

Carla described a scenario exemplifying the complex needs of older adults compared to younger populations and how this impacted her treatment plan. She talked of an increased need for awareness regarding specific precautions.

> I think [seniors'] needs are way more than, say, the adult population who have one diagnosis. Because then you can focus in on that one diagnosis and deal with

> it, whereas with the geriatric population, … you've got an old stroke who has fallen and then fractured their hip, and then during the surgery, has had a heart attack, and then they've gone into congestive heart failure, and they're also diabetic, and they have arthritis and they can't use their hands with the regular walker, so you have to perform weight-bearing, and then they have some cognitive impairment, so then they can't follow the hip precautions properly. So in that sense, with the complexity, you have to be far more creative in meeting their rehab needs, because they still want to go home within that setting.

Participants shared how their thinking had changed over time related to the approach used with older adults. They spoke of reframing their approach as they gained more experience. Jane shared the following

> It must be from school; because I started as a new grad…thinking I was going to get people improving and getting out….The attitude that OTs are to improve function. I know it says 'to maintain or improve' somewhere … somehow I grasped onto the 'improve'…..Now I see that… small gains are important for that person, and it's more individualized. Like, when a person doesn't have that much potential, for them, just making a transfer is probably as huge a gain as somebody [else] who's gone back to the community. Maybe they didn't expect to be able to transfer themselves, so when they do, that's really good.

The complexity of care was viewed in both a positive and negative manner. When confronted with this complexity, the right knowledge, skills and attitude made the

assessment and management quite gratifying. Participants commented enthusiastically on how they viewed it as an intellectual challenge, describing how the medical complexity kept their work interesting and enabled them to use a wide variety of skills. As Brittney shared, "The challenge is always there. There's always the opportunity to learn something more." Alison echoed this notion

> That is what I really like as the OT, because they're not straightforward cases. It makes the job more challenging, but more interesting, because there could be some other area of the OT model that needs a little working on, or setting people up with more supports.

Therapists also referred negatively to the medical complexity, frailty and chronicity of their clients. Emma shared an example of how she felt frustrated with the frailty and lack of progress she encountered with some of her older clients.

> If a person comes in [to this long term care centre] with a stroke … these people are already frail….They often come with cognitive difficulties, so you have not only the physical impairment, you have the cognitive impairment. So trying to get somebody to relearn something when they already have a cognitive impairment is extremely difficult…. they're walking around, using a walker, and then they fall and have a hip fracture…and they… [have] this complex plan of the number of exercises they need to do and how much weight-bearing, and the precautions, especially not to flex it more than 90 degrees at the hip…. They don't understand those things, so it makes it difficult, because now that person's immobilized, and

they also don't know how to help themselves. You try to help them and it's painful, and they don't understand that it's going to hurt a little bit, but it's part of the process. So that's resulted in some of the residents not regaining mobility and just staying in bed and further getting confused without the stimulation. I think that that makes it difficult for me to see, because I know what they should be doing, and I'd really like to help them, 'cause they've got so many strikes against them already.

Comments were also made regarding the challenge of performing proper assessments on older adults with multiple health conditions as the standardized tools were typically based on younger populations or on older adults with limited complexity in health conditions.

Images of increasing levels of deterioration, dependency, and disability, especially with clients whom therapists viewed as having been previously active and independent individuals, were seen to be a source of concern amongst participants.

I think you just see it all the time. Let's say you've been working on reducing a pressure wound for the last 3 months, and you've had it healed up…and the pressure wound opened up again. It's just so disheartening …. I really have a hard time seeing people deteriorate. [Ana]

It's frustrating sometimes when you work really hard with someone and they don't get better, and you put in your best effort, and they put in their best effort,

> and to see them so upset and devastated and crushed. A lot of the elders, when they find out that they're not going to be able to go home or be by themselves again, they're just devastated, and it's awful to see them like that….So that is probably the worst part, is seeing people not be able to go home or reach their goals. [Brittney]

The oral accounts were corroborated with participants' written accounts. When participants were asked to write about a scenario where they felt dissatisfied as an occupational therapist working with older adults, situations were shared where occupational therapists were unable to achieve a specific outcome or prevent deterioration of the client's health status due to their medical complexity.

The medical fragility of many of these clients had an impact on motivation and progress. One participant talked of how some of her clients argued they were unable to complete the task at hand, all the while the therapist felt very confident in the clients' capabilities and needed to provide increased encouragement. This fragility and chronicity seemed to also have an impact on the perceptions of some therapists. As Jane shared, "What are they striving for? It's sad, but I think that they are biding their time. They know that they're not getting better and they're not going back home again, so their main source of enjoyment is their family contact."

Generalist AND Specialist. Participants spoke of their schooling preparing them to be 'generalists'; providing brief training in a variety of areas with respect to working with older adults. Similar to most new employment opportunities, much is learned on the

job. These participants' experiences were no different. Once they started working with older adults, they needed to obtain knowledge that went beyond what was taught at school. They spoke of seeking mentors, reading journals, contacting resource centers, and joining OT resource groups to learn about a variety of issues in which they lacked knowledge. As Ana stated "All these different things *can* be quite a specialized area." Having gained more experience while working in the realm of aging, participants spoke of the requirement to acquire knowledge and experience in a wide array of areas. They explained that this was necessary due to the multitude of health issues with which older adults present.

> In terms of skills and knowledge, you need to actually pull from all the things that you've learned in school: physical assessments, sensory assessments, cognitive assessments looking at all those areas, because… we're looking at the whole person, and in geriatrics, because it is more complicated, you do need to be able to assess all those areas. Knowledge in specific diseases, very important: arthritis, osteoporosis, dementia, those three being, I would say, quite on top of the list there. [Linnea]

Brittney described a client with whom she worked.

> You have to know a little bit about everything, because everything will come up. …. I had a patient once … she was deaf and mute, she had depression, she had bilateral ankle fractures, and epilepsy. It was the biggest challenge, even the communicating, going in every day and working with her. And her home

> environment she lived in … a townhouse condo with stairs throughout it. So this was just a challenge to get her home, but we did.… you learn a lot about everything.

Several other occupational therapists commented on the need to have an expansive understanding and be proficient when working with the aging population. As Emma articulated, "I find it very challenging and very exciting, because you have to be a jack-of-all trades in this type of job, and you have to have a lot of different skills." Ana argued this broad requirement was more common than when working with other populations.

> I've learned an immense amount of knowledge since I've been there in all areas- physical, psych, cognitive- everything-…areas that most people that I talk to- my peers- don't necessarily have the opportunity to go in that many areas.…My peers…that work in different areas, they say, "I can't believe you have that broad of a position where you're dealing with all of those different things." 'Cause often…OTs working in schools, they're working with scissors or cutting and printing, and that's probably all they do in a day, so I shouldn't say "all," but the major component of what they do in a day so they've become very specialized in that area. Whereas on any given day, I could be doing an assessment on cognitive, and then the next day, ADL, and the next day, dysphasia, and then doing skin and wound care, and I could do all that in one day, too; you don't know what's going to come up. So I have a very broad job.

Ana also said that a key factor in her decision to work with this population was the ability to obtain a wide range of experiences within her current work setting.

> I've learned an immense amount of knowledge since I've been there in all areas: physical, psych, cognitive everything dysphasia; areas that most people that I talk to, my peers, don't necessarily have the opportunity to go in that many areas. So I did want a job with a broad range of knowledge, to get a number of skills before I went on to do something else.

Due to the complexity of the health of older adult, not only did therapists speak of requiring a broad *array* of knowledge; but they spoke of needing a *depth* of knowledge as well as special skills that were pertinent only to this population. As Carla explained, "you have to specialize in understanding the subtleties of all these different areas." Summer provided an example of the depth of knowledge required in one specific realm, cognition.

> [OTs working with older adults] go so much more into cognition…we do some of the same tests and some of the same screens, but what it means to our population and what we have learned over time when we see the person repetitively, we're …much more aware of what the tests we do will and will not tell you, what the pros and cons are, what the scores can and can't mean, than maybe [compared to] OTs in the other areas…because it's not as big an aspect of what they're doing, as what it is for us. 'Cause that's a huge area of geriatrics.

Hanna expressed that the medical system in her city was acknowledging these specialized and complex needs by developing specialized teams and programs that addressed the unique needs of special groups within the aging population. She shared three examples: (a) a geriatric rehabilitation program, (b) an assessment service for frail elderly and (c) a program providing assessment, rehabilitation, treatment of psychiatric illnesses and related psychosocial problems specifically for older adults in the community. She stressed that they were "multidisciplinary, because these folks are so complicated."

Two less experienced occupational therapists disclosed that they were unsure as to whether they were providing the optimal care required for the specialized needs of their older client. Emma talked of not being able to "master any one area" at that point in her career. Ana revealed

> Because right now, I don't see that older adults are getting the specialty in care that they really need.... my concern is, with the multiple types of diagnoses that you're seeing, and all the interrelating things with each diagnosis, it's really hard sometimes to assess an older adult in the proper way, and to do the right interventions to make sure that you're not going to cause harm to them from some other diagnoses they have, make sure that you're treating it in the proper way, and having everyone involved in that.

Therapists emphasized needing both a broad array of knowledge as well as requiring specialized skills and knowledge in order to provide optimal care for older adults. Each of these abilities alone risk negative outcomes. There is the adage "jack-of-all-trades, master of none"; as well, having specialized knowledge risks limiting one self to having a narrow focus. While these two abilities may appear contradictory to each other, within the realm of gerontological occupational therapists they appear to exist in harmony. There appears to be a sense of mastery of what I would discern as being both a generalist AND a specialist.

The data suggest that gerontological occupational therapists require the focused knowledge of a specialist, along with knowledge in a vast array of areas and global issues. Participants spoke of being able to look at the wide array of areas and see how they are intricately intertwined with one another, all the while being able to integrate them all together. As Carla explained, therapists require "a broad range of knowledge and [be able to] delve deeper when you need it." Linnea likens it to "investigative work." The more experienced therapists seemed to talk of traits that fit within this unique realm. They spoke of being consultants, educating others who already worked with seniors. They talked of being asked questions focusing on particular issues and concepts within the aging realm. Participants spoke of having specialized knowledge in a variety of areas such as wounds and edema, or cognitive testing. As Chris shared, "I have to basically let [other health professionals] know what [a specialized aging concept] means, what the values are, what the risks are."

Carla, an experienced therapist spoke of what was required of her at work. Her story reflected the demanding nature of being a gerontological occupational therapist. She first spoke of the need for a broad range of knowledge.

> So I need to understand stroke. I need to understand spinal cord, because I have spinal cord patients. I need to understand orthopaedics; I get all kinds of fractures, and I get total shoulder replacements as well as total hip replacements. I get all kinds of arthritics, whether it's RA and OA, all kinds of diabetics, all kinds of visual impairments, all kinds of legally blind people, all kinds of hearing impaired people. Then you put it all together. So yes, you need to have a broad range of knowledge, but it allows you to delve in deeper when you need to. So the neurological ones I see more of are the Parkinson's disease, but I also get supernuclear palsy, I get ALS, I get Guillain Barré. I get all of those

She then spoke of the specialized knowledge and skill that was required.

> If you see a total hip in an 87-year-old, it's different than a total hip in a 50-year-old. There's a total hip program for just 'well people', but then you throw in all of these other medical conditions on top of it. 'Cause they've got…an injection fraction, a patient with an injection fraction of 10 to 15 percent, which is abysmal. Normal for geriatrics is 60 percent. This patient shouldn't have been walking independently and doing what he was doing, but he was independent. Independent of ADLs, independent transfers, independent ambulator with an injection fraction of 10. He was considered end-stage palliative, cardiac wise. So

how is it that you can have this on paper and see this in person? That's the beauty of, that's the specialization in geriatrics, is that you mesh it altogether, and you mesh all of this information together, and that, I think, is the specialization.

Participants shared that the secret to being a successful gerontological occupational therapist was knowing their limitations. As Hanna stated, you need to be "willing to admit that you don't know everything; being willing to ask questions about finding that information out." Participants spoke of recognizing instances when they were capable of performing a task adequately and when they needed to call upon someone else who may have more expertise in the area. Expanding on this, one can interpret that if an OT felt the need to be a master of an entire area, then working with older adults may not be the optimal fit.

Ana shared an experience that demonstrated that not all health professionals working with older adults have the abilities to see the 'entire picture' as do gerontological occupational therapists.

I went out to assess one lady one time on outreach. [The other health professionals] overlooked the biggest thing that was causing her problems, and it was a whole team of people. We had a discussion with them, and they overlooked that she was depressed. When we went to see her, she was crying. I couldn't see why they couldn't see that. Instead [they were] pushing this woman to walk further and further and do more for herself, [but] she physically wasn't able. And she was depressed because she couldn't do it.... And they weren't adapting her

> environment for her.... I don't know if that's a tunnel vision kind of thing...That was a case on three separate clients that I saw, where it was just so right there in front of your face....I think they were so involved with "she had to walk."

The multiple health problems experienced by many seniors are central to the necessity for receiving complex care. It is apparent by the stories told by participants, that in order to work proficiently within the realm of aging, one needs to have an extensive knowledge base in age-related topics as well as the ability to delve deeper into each issue while integrating all issues with one another.

2) Life Stage

Participants spoke of their older clients as having reached a stage in their life where they had lived a full life and were now approaching death. Participants shared particular traits and issues that appeared to characterize this stage of life.

Wisdom acquired. Participants perceived their older clients as being wise and having lifetime full of rich experiences. Carla, an experienced occupational therapist characterized many responses by saying, "The really neat thing about the geriatric population is they're extremely wise and they're also...realistic. There are a few that aren't, but most are....I think it'd be lovely if we had...more time to just listen." Summer talked of this population having insights and knowledge that younger populations did not have, "it's like they know something that we don't."

Wisdom was associated with having life experiences from which to draw upon. Linnea shared an example of this wisdom.

> They're full of wisdom, they've lived life, they know a lot of 'remedies'... different from the things that I can teach them or the things that the medical field can teach them.... We need to respect the amount of wisdom, knowledge, experience that they are coming into the working relationship with the OT.

Emma illustrated another example. "When you're working with them, sometimes they do realize, 'Are you a little nervous working with me?'...they have that understanding, that intuition about what's happening, what you're doing." She also believed that older adults with cognitive impairment were not excluded from this trait. "Although some of them obviously have cognitive impairment...there's still...this wisdom that they share and impart with people around them."

Alison, who was reflective during her interview and appeared to be grappling with many issues, talked about how the wisdom and autonomy of her clients also presented with some ethical challenges.

> I'm young, and they have a lot more wisdom than I have, and... I ... say..."This is what I recommend; ultimately, you have the right to decide if you're going to follow my recommendations." ....I still have to respect their choice, but I ... still have to cover my butt for XXXX (the professional regulatory college) or for whoever could come down on me. You don't want to look incompetent, but still,

people have the right to choose if they're going to listen to you or not.

Some participants revealed that they did not always enter their career with an appreciation of what seniors can teach them. Linnea talked of how her perspective had changed as she gained more exposure to this population.

> When I first started, I may not have had that perception [of respecting the wisdom of seniors], and I think I might have gone into the working relationship thinking, "I have something I can offer them," rather than, "I can learn something from them as well," or "We need to do this collaboratively, otherwise it's not going to work."

Others, like Hanna, changed their assumptions that wisdom comes with age.

> I think that's one of the hardest lessons that I learned the first year, was that wisdom doesn't come with age; wisdom comes with experience and with learning. You can be a cranky old so-and-so that doesn't know anything and be 85; just because you're 85 doesn't mean you're a special person, it just means you got old.

End of life. Losses and death are inevitable and a necessary part of life. Predictably, the older cohort is closer to death and has experienced more losses than younger people. Participants talked of the abundant amount of losses that this population has lived through. As Jane articulated

> The elderly have lost so much to come [to her long term care facility]…they've lost all their freedom, they're probably widowed, they've lost a lot of their friends, they're more cut off from their family…they can't go to the mall…they've lost their homes and all their furnishings….I think they need a bit more compassion and understanding than somebody who's just briefly [sick] or is going to get better.

Participants talked of end-of-life issues and death in their gerontological experiences. The most common reference to death and dying was not from their own perspective, but perceptions of others. Participants reported that friends, coworkers and the public in general, stereotypically perceived that working with older adults was seen as a task devoid of hope. As Brittney suggested, "Others think, 'Oh, geriatrics is the end of the line'." Summer disclosed, "There is a lot of the attitude that these people are at the end of their life…they're going to die soon anyway." These comments appeared to indicate that working with older adults is societally equated with death. Thus, death was viewed as a primary focus and the setting within which gerontological occupational therapists worked was seen as sombre. In contrast, when participants themselves made specific reference to death and dying, it was in a more neutral light. They expressed that death was just one piece of the bigger picture within the experiences of working with older adults. They spoke of death and end-of-life issues with a sense of rationality, appearing comfortable to talk about their experiences. Death seemed to be accepted as inevitable and just one more stage of life. Carla, in a rehabilitation setting stated matter-of-factly, "Your clients *do* die." Christina in home care articulated, "You're dealing with someone

who's at the end of life, and they might die soon."

Contrary to the negative stereotypes, participants were more optimistic and found positive aspects in working with older adults who were near the end of their life. They approached their clients with a great deal of compassion. Participants not only recognized the importance of providing quality in life for these clients, but also quality in dying, when improvements were no longer a possibility. Christina shared that one of her most rewarding experiences when working with older adults in home care was "helping them make that final transition… when they pass away." Carla revealed a sentiment that was echoed by others.

> There's lots of our clients that, they're of the age that they're going to die, and they die here, and they die not long after they go, and you just hope that you can help them die the way they want to.

But even when end-of-life issues appeared inevitable, death of clients did not come easy. Participants talked of it being "heartbreaking" and "difficult" when clients passed away. Tanya shared her experiences of the difficulty of working with clients who were dying

> It's difficult when some residents pass away….the palliative care side of everything… I didn't think I was as prepared as I could have been…. I think, all of the staff here have your residents that...you have the closest bonds to. So when they do pass away or when they get sick, you go through that up and down.

She also spoke of the ongoing variability of health status of many of her older clients who were near death.

> That's the thing with the geriatrics I hadn't expected, is …the nine lives and the rallying that goes on. When they get ill and they have dementia, and you think, "Maybe they'll just pass away," but then they rally, and then they [laughs] go down, and then they rally. So the up and down …The rallying is what I find the hardest with palliative care, when they come up and then they go down.

Participants talked of "moving on" and "latching onto" and becoming very attached to other clients following the death of special clients. This healing process seemed to be facilitated by seeking external support by others including team members and significant others.

Adjusting to the increased possibility of death required a change of outlook on the occupational therapists' part. Chris talked of how the regrets people expressed when they were dying ironically helped him live his life to the fullest. Tanya talked of how her perception had changed about working with older adults in a long term care facility.

> When I came here, I would get so upset when people would say "You work with people that are dying." "They're not dying, they're living!" Now I have a perspective that it is more like an end-of-life care when they come here, except for a few select residents that maybe have different goals. But most of the

residents are just interested in making the end of their life happy. But it is the end of their life, and they talk about it that way, so why should I talk about it differently.

Slower pace. Generally speaking, the interaction pace between occupational therapists and their older clients appeared to be different than when working with other populations. Interactions with the older clients often appeared to be unhurried. Therapists reported spending more time listening and talking with their older clients. Participants also commented on the fact that older adults moved slower than other clients and this also impacted the interaction pace. As Linnea explained, "I think you've got to have patience; that's a really good virtue when you're working with a senior population, 'cause they do everything slower than you do." Ana suggested, "you really can't rush older adults, because it gets them agitated, it gets them frustrated." Carolyn provided further explanation for this slower interaction pace

> Physically the older people move slower, so while I could probably do an ADL assessment of a younger person probably in 15 or 20 minutes, I'm probably looking at 45 minutes for an older adult. Because I think safety issues are more crucial there because most of them have mainly hearing losses, balance problems, and all that, so you have to go a little bit slower to give them the best chance of doing it as they can. If you rush them through you probably don't have a really good idea. Whereas with a younger person you can let them do it fast and you have a great idea how they manage.

Carolyn also suggested that younger therapists appeared to have a harder time working with older adults due to this slower pace.

Even though participants felt that taking more time to listen and assess their older clients was extremely important, participants shared that often times they did not have the time to listen and assess thoroughly and felt guilty of this. There appeared to be a clash between the push for efficiency and speed within the medical system and the time required for the needs of seniors to be heard.

Having reached their senior years, this group has acquired traits that are distinctly linked to their stage in life. Wisdom was an admired trait observed by many participants. A large amount of seniors were perceived has having this trait. As well, death and end of life issues were prominent within participants' experiences. Death was not talked of in a disparaging manner but was accepted with a sense of rationality. In conjunction with this life stage, occupational therapists talked of a slower interaction in order to accommodate for seniors' decreased speed in completing tasks; as well as an increased prominence in safety concerns.

3) Current Cohort

Participants viewed their older clients as distinctively different from their younger counterparts. Older adults have a long history of facing life's challenges and have experienced numerous life circumstances which have had an impact on the realities of this cohort. This group grew up in a time when health care was not universally accessible. Thus, it could be argued that this cohort does not take Medicare for granted.

This cohort experienced financial hardship during the Great Depression when there were limited social and health initiatives leading many to learn the importance of being self-reliant. As well, this group experienced more losses in their life than the younger counterparts. Their losses accumulate, each loss adding to, not replacing, the last one. These experiences have inherent implications on the attitudes and traits of today's seniors. Summer talked of this uniqueness within the older adult cohort and the impact it had on seniors' ability to deal with change.

> I think there's just a different attitude. I think coming from a different generation....the people we're seeing are people who...lived through the Depression, have lived through the war, saw the technological changes, and have just rolled with it. So when new things come up that are different, whether it's a change in their health, I think they're able to roll with it a little better than I think younger people...change has been a constant.

Three sub-categories evolved from participants stories related to the uniqueness of this cohort. They include being: (a) isolated, (b) less demanding, and (c) more appreciative. It is important to note that several therapists commented on the fact that each senior is unique and evidently not all seniors fit each description and thus the comments made were generalizations.

Isolated. There was a sense amongst participants that older clients felt disconnected from others. Ana and Linnea talked about the phenomenon of the older population having gone through the medical system so many times, yet many seniors had

not connected with anyone; nor had anyone actually listened to them. As Ana said, "I try to…really listen to what they have to say…often times that's all they need." Hanna shared, "This is a chatty population. Because this group doesn't have anybody that they're talking to during the day, and they really need to talk, and some of them are so lonely." She suggested this can be alleviated by determining ways to engage them in social activities.

Ana talked of her switch in priorities and the importance of connecting with her older clients, as she gained more experience working with this population.

> I always thought, "I can't stop and talk to this person because I need to do this and this and this," and I felt like it wasn't part of my job to socialize with the residents. But really, it is, because the residents need that, and you need to develop the rapport with them. You're not going to get anything done otherwise.

Doug echoed this idea, as he disclosed his sentiments towards the importance of befriending his clients. "Five years ago…I was thinking did I do a good assessment, did I do the right cognitive tests, things like that…. My success now comes from… was I friends with them."

Supporting this perception of disconnection, Emma expressed how she felt that with this population, one of her primary focuses was on making older adults feel like they were still contributing members of society.

> You have to maintain a lot of their dignity and make them feel like they're contributing, like asking them, "Can you teach me how to knit a scarf?" or "What was your favourite recipe? Can you tell us what you used to do when you took care of your family?" So really putting a lot of emphasis on their individuality and their ability to make choices still, and to have some control, and to interact. I really focus on productivity here so that they can feel like "I'm an active member of this community at [name of facility], and I'm not on my way out."

Less demanding. Occupational therapists spoke of the fact that there appeared to be a decreased persistence found amongst many older adults with whom they worked. Participants, throughout different work settings, shared their perspective regarding how many older clients, in comparison to younger populations, were less likely to be 'pushy', 'assertive' or 'demanding' and appeared more concerned with taking too much of the occupational therapists' time.

Alexandra, who worked in a long term care facility, stated the following

> I don't know if it was just the[younger] client group that I had I don't want to make generalizations but [the younger population] were a lot more assertively demanding of what they wanted. They knew what they wanted, they had a vision of what 5 years would be like, so they demanded treatment, they demanded a certain level of [pause] interaction… they wanted your time. Whereas … with the seniors…I have to be more proactive. Very rarely do they come and say, "I need this." Instead, I have to go and work it from them, through assessment and talking

> and looking and observing....So I more have to broach it with them, and/or their family. So to me, I felt, even with the very dependent young adults and even dependent in terms of their cognition they could be quite cognitively impaired somehow, they still had more of a drive to question .... they'd call you all over: "Hey, hey, hey, hey, hey," even if they couldn't talk or whatever and you knew that they wanted something. I could walk past the same people here [in a senior's center] and I don't think that they would ever call.

Christina, an occupational therapist in home care, shared similar perspective.

> I think generally, [seniors] are probably less demanding... I have to tell my clients I've got a pretty high caseload, that if they have problems, that they need to call me, because that's the way that I work. I say, "If I don't hear from you, I'm assuming that things are going well." So it's generally my younger population, they will take me up on that, and they will phone me when there's something wrong, whereas sometimes I know some of my seniors don't always do that.

Participants offered several hypotheses as to why seniors appeared less demanding in comparison to their younger counterparts. Perhaps seniors viewed it as being impolite and bothersome to the health professional or that seniors were not up for the struggle of fighting for what they wanted. As Alexandra explained, "I get the sense that [older adults] don't like, as much, to put a burden on younger folk.... Not everybody, but I'm trying to be a bit general but they feel [pause] maybe it's not polite to ask for the help?"

Brittney spoke of occasions where older adults acquiesced because of a desire to please others. She provided an example where a client moved from her home into a facility even though she did not want to because she was not up for the fight of going against her families' wishes. The most common suggestion as to why older adults appeared less demanding was that unlike the younger population, older adults did not have the same sense of entitlement in receiving assistance or equipment. Summer, who had worked with younger adults earlier in her career, compared this sense of entitlement between the two populations.

> Younger people… are sort of much more entitled. [Older adults] don't have the same sense of entitlement. It's like, "….I know that you're the professional and you know things, and I'm hopeful that you can help me," but it's not that same sense of entitlement, where [younger people would say]…"You owe this to me….. I don't have to do anything here." I don't find that in the seniors that I work with. There's much…more recognition that there's work on their part, and they're willing to do it, because they've worked hard their whole life. Things haven't come as easy to them.

Christina spoke of having to adjust her approach with seniors to accommodate for this sentiment of not feeling worthy of receiving her time and assistance. "I have to say to them, 'No, that's my job.' …..Maybe they feel there's other people that are more worthy of my time. So I have to say, 'No, that's not true. You do need help and my attention.'"

However, not all therapists shared the belief that seniors, as a cohort, tended to be more passive and less assertive. Some participants mentioned that this population appeared to be more confident than the younger population. Ana shared the following perception

> But older adults are funny; they are going to tell you how it is and what they want. If they're able to, they're going to show you or tell you somehow what they want. And they don't really want to take any kind of crap from anyone!

Supporting this notion is a comment made by Carolyn.

> I think they've just been through so much that they can just sort out the junk from the real stuff. .... I think they're... more confident in themselves. Some are. Most are... some aren't. Just confident enough to say that if they don't want your help; if they don't think they want to do it that way, they'll tell you.

Appreciative. Participants seemed to indicate that the older adult population in particular seemed grateful of the time and energy spent by occupational therapists. Participants reported satisfaction in this appreciation received from their older clients. Jane shared, "Residents are giving you so much positive feedback, just for stopping to look at a wound... they're thanking you up and down. I find that you get so much out of them.... They thank you for every little thing."

Linnea stated the following

> They're so appreciative of everything you do. A simple phone call just to follow up: "So how is that bath seat working out for you now?" or "Did ADL contact you about your stockings yet?" They're so appreciative of any … contact that you make. Then when they thank you for that, it's just a heart-warming feeling.

Some therapists made specific reference to populations such as older adults with dementia and those who have experienced hip replacements.

> Especially the Alzheimer's; they're so appreciative of everything you do, and complimentary. I come home and I think, "It's lovely to work there," because you come home feeling good about whatever you've done. [Jane]

> The other thing that I find really of value here is working with people who have had hip replacements. Now there's a little bit of surgical pain, but it's nothing like that old arthritic hip pain that they had before the surgery. I find that they really value to take care of their hip and to follow our suggestions … because they're just so much happier now that they don't have that old nagging, debilitating pain that they had before. [Alison]

Jane talked of the historical influence on this cohort when she explained why this group in particular seemed so appreciative of her help.

> I think having to work hard for things makes them more appreciative of what they do have, and appreciative of your time, too…We're so used to the government looking after us, whereas the older generation, I don't even think they had medical coverage in the early 1900s, so they're not used to being given everything.

Participants talked of needing to connect with the client and nurture their relationship because many seniors have been isolated and ignored during previous experiences within the health care system. While this group of older adults often presented with traits of being lonely, appreciative and less demanding than their younger counterparts, one can not predict whether or not these characteristics will define future older adults. The next cohort that enters into their senior years, the baby boomers, will "not suffer in silence". (Nowaczynski, 2007).

Environmental Influences

Participants' experiences were intricately intertwined with external environmental influences. Three categories that emerged from the interviews of the participants' included interpersonal relationships, work conditions, and ageism.

1) Interpersonal Relationships

Relationships of three groups of individuals were deemed particularly important when working with older adults. These groupings consisted of clients, co-workers, and clients' families.

Clients. Participants seemed to relish the relationships they had with their older clients. Tanya, who worked in a long term care facility enthusiastically remarked, "I love it here! Yeah, I really love it" Others shared similar sentiments.

> I really enjoy working with the elderly. They've got so many stories to share and so much information. It's a challenging group, but very rewarding...if someone comes in and they've had an illness or an injury and they're quite dependent, and you're able to work with them and their goal is to get back home, and you're part of helping them reach their goal, it's very rewarding. [Brittney]

Alison, who worked in a small town, appreciated the life histories.

> I really like working with seniors....I'll go upstairs, and they'll see my business card, and they'll read my last name, and they'll go, "XXXX (name)? Do you know the XXXX (name) from wherever?" ....it turns out some of them went to school with my grandparents! Like, that is so cool, just to be able to talk to people about your history.

Some participants talked about working with older clients with minimal involvement from other health professionals. They spoke of being the only one who believed in the potential improvements after a client had had a stroke; or investing time with dying clients to set goals determined by these clients; being the only one with whom an older adult with Alzheimer's related to; advocating for clients who wanted to go home when others felt they did not have the ability; having to do the research on new equipment

without the assistance of other team members.

In community settings, there was particular reference to the value and opportunity to develop long term relationships with their clients. As Jane revealed, "…you get strong relationships that you build with people over time, which I think you might be missing in the other settings, where they come and go." Alexandra's comments supported this notion.

> I really enjoy the continuing care environment, where you're with someone most of our people aren't discharged to home, this is their home, and so I'm with them till they die. So I get to be with them through their changes, and try to make life good for them, as much as possible.

Alison, an occupational therapist who worked in sub-acute care but who previously worked in long term care noted, "I felt like I was more connected with the clients before, in long-term care." This notion was also supported by Doug who worked in acute care. "I'm not as connected with [clients] as some in the community setting." Christina, who worked in the long term division of home care, talked of establishing rapport and following them through, seeing them maintaining their independence.

> It's important to actually have a relationship. I've got [clients] that just phone me up…and they don't have to say their first name… you just know who it is. Yeah, that makes the job more rewarding.

These narratives demonstrated that participants in home care and in other community settings articulated that long term relationships with their clients were prevalent, important and rewarding. However experiencing long term relationships with clients was not just isolated to these settings. Surprisingly, even in acute care where clients are typically seen for very short periods of time, there was mention of occasional opportunities to develop long term relationships. Doug commented on how, within acute care, certain clients just kept coming back and being readmitted and thus long term relationship were developed. In addition, due to long waiting lists for long term care or rehabilitation settings, some clients stayed in acute care for a month or more awaiting placement. Carolyn, another acute care occupational therapist, commented on how she had the opportunity to see some of her clients over extended periods of time as outpatients.

Some issues impacted the older client-professional relationships. Hanna talked of a variety of challenges.

> The first week I worked as an OT, I was asking somebody about how their incision looked, and she just dropped her pants right in front of me! [chuckles] It's getting used to… the nudity. Sometimes the obsession that some people have about describing every intimate bodily detail about [pause] their bowel movements, or [laughs] …they have to tell you their story about the hospital…. It's 793 times more important to them than it is to me. So letting them tell me their story, that's sometimes a challenge, especially if I don't happen to agree with what their opinion may be.

One issue in particular was that of challenging personality traits (e.g., being verbose or stubborn). Doug shared the following

> Older adults, you know, they lived 30, 40 years in their house and to take them out of that is a big step and... sometimes they're stubborn and their insight is not there....They're like "I've lived this way for 40 years. You can't take me out of it. Leave me there. Leave me home. I've had it for years. When they might have...a CVA or something and they can't even transfer. They don't realize how much stress they put on their wife. Like just stubborn.

Along with personality traits, sometimes clients' beliefs and values strongly conflicted with those held by the occupational therapist.

> I have one lady who kept on firing her personal care aides because they weren't white. When I went out there to have a conversation with her about it, she started singing a song about "One Little, Two Little, Three Little Indians," and clapped her hands, and was ... generally making fun of the native population. I had one lady who fired me because her dog didn't like me; her dog thought I was up to something....it's the different value set that's difficult. Or the fellow...whom I was treating for an unrelated injury, and was very clearly...abusing his wife...what do I do about that? It's not necessarily an easy situation. [Hanna]

Another issue revealed was that of attending to physical detail and function (e.g., foul body odour, incontinence). Participants spoke of how this population seemed to be more

comfortable talking about their bodily functions. Carolyn articulated "I have lots of older people who say 'you know, my hardest problem is my size and I can't wipe behind when I go to the bathroom' but that's a really hard thing for younger people to say." Hanna candidly shared

> They can [have] poop all down their backside; you know they've had an accident, they need [a bath]; and that's really not a fun experience!....Trying to teach somebody how to use their incontinence products, and then having them pee on you. Smelling wounds that have gone bad.... I think the odours really get to you. If things don't smell bad, generally, I think most of us wouldn't have a problem with that, but a lot of us as OTs have said, "That's why I didn't become a nurse." I don't want to deal with that sort of stuff, the smells, the oozing. Anything that [laughs] has the word puss attached to it, yuck!

Doug identified the challenge of age differentials. When occupational therapists are younger, there may be a decreased ability in identifying with their older clients. Doug spoke of the fact that he related better with his younger clients.

> I get some sort of satisfaction out of comparing my life to theirs, I guess. We talk about where they are in life. Or I like hearing about the kids they have.... How they got married ...and... younger ones ... I can identify with them a bit easier. They're closer to my age.

In the course of establishing a relationship with clients, ethical issues frequently arose, posing special challenges to participants. Some common ethical concerns included resolving conflicts between clients and decision makers, competent older adults choosing to disregard assistance by therapist when they experienced physical, psychological and financial abuse by family members, competent clients making unsafe decisions (e.g., declining wheelchairs and walkers, returning home when at high risk of falls), and the inability to obtain opinions and choices from cognitively impaired older adults who have no families. Participants spoke of these issues as being challenging. Emma recalled an older client who was being abused by his wife.

> We'd ask him if he wanted us to do something about it, and he said no; he just knew that that was the kind of person that she was. As a facility, we wanted to get involved for him, but he didn't want us to because, he said, "I've lived with this my whole life." So …it's very difficult.

Coworkers. Gerontological occupational therapists do not work in a vacuum, nor can they isolate themselves from contact with other key players by the simple fact that an occupational therapist's responsibilities include direct contact with others. In a time when interdisciplinary team work is highly revered, participants talked about challenges associated with a team approach. Linnea explained

> I think the stress is, in any profession or any new job that you come to, it's just learning how to work with the other team players…. I have never worked so

closely with a nurse before, so yes, there have been some difficult moments. I persevered; I've gotten through them, so that's fine.

Other participants reported the following

> Teamwork…quite often, it's us against them. Who that "us" is and who that "them" is changes on a day-to-day basis, but there's a lot of that, where it's "you said," "we said," that kind of thing. [Alexandra]

> The staff did not work together to achieve goals. Sometimes staff do what is convenient without considering the impact on the client's function. [Emma]

The relationships that seemed to be the most strained were those with nursing. Therapists spoke of the challenges they experienced when trying to have nursing staff use the assigned equipment properly.

> For the staff here to manage, [the splint] never got put on right, and no matter how many times you showed them, they couldn't manage it or they can't figure it out….it's not functional for them in that position….[so] the resident them self wasn't happy. [Tanya]

> And you'd do your best, you'd make this splint and put all these pictures on the walls of how to put it on or how to take care of it, and then it would come back from laundry. They'd put it through the dryer and it was [laughs] like a crumpled

> old mess. I just found it was hard communicating there. It got me down because it would seem like all this work that I was doing the cushions would never get in the right way; they'd be face up, wood part up. [Alison]

Interestingly, the tense relationship with nursing seemed to be reported more commonly amongst occupational therapists that worked in LTC settings. In the larger institutions (i.e., acute care and rehabilitation settings) there appeared to be more positive interactions with nursing. Brittney who worked in LTC prior to working in a rehabilitation hospital explained that she found there was a difference in the relationship with nursing between settings.

> It's a rehab hospital, so as an occupational therapist, you're part of the team and without the physios and OTs and speech language pathologists, it's not a rehab hospital. So you're respected; people know what you do, what kind of work you do. Where, I found when I worked in long-term care, they had no idea....whereas here at XXXX (name of hospital), I find that they know what an OT does, and my referrals are appropriate, and they value what you have to say, and they listen and they ask you. So my working relationship with nursing is... actually very good.

Another member of the team whom participants seemed to sometimes have tense relationships with was physicians. Hanna shared her experience.

> The one discipline that continues to be a challenge, from a perspective of lack of respect for other disciplines, is the medical doctors....And it's not all of them, but

there's a fairly high proportion. And that is a group, as a discipline, that will not ask questions… I have never, ever once been consulted by a physician about what would be a good therapy, what would be a good choice…. And the number of times that I've called to the physician to say, "Well, I've assessed this person. In my opinion, I don't feel that this is an appropriate course, x, y, z; I think we should do a, b, c." One in two of those physicians that I will talk to will have a distinct problem with me [pause] telling them their job. And in fact, I've had several doctors just go right up one side and down the other about "How dare I?"

Despite the challenges related to working with other individuals, participants also commented on how they appreciated working on their team and working with their coworkers.

Clients' family. "I think when you're working with older adults…you work a lot with the family" [Brittney]. Families have an important role in the care of older adults. As Jane shared, "[Older adults'] main source of enjoyment is their family contact." Incorporating family members in a partnership with the health care team enables a collaborative approach in recognizing the clients' individual needs and preferences. Throughout the first eleven interviews, I did not ask direct questions regarding participants' experience and opinions of working with the family members of clients. However, the majority of participants, talked unprompted, about family members when discussing their experiences of working with older adults. Family involvement in the care of loved ones had both positive and negative implications.

Linnea routinely involved family when working with her clients and talked very positively about her experiences with the informal caregivers. She talked of the importance of incorporating family members into her 'best practice' approach.

> It's actually a challenge for me, going into this home, because not only do I have the client that I am servicing… I'm also working with the caregiver, so I've got two clients, so it makes it doubly challenging for me as a therapist going in. But it's such a rewarding experience, because you leave the visit and you actually feel that you have made a difference…. I may see something separate that I would want to introduce to the caregiver, but if the caregiver does not also agree with that, of course, there's no need to go further. But it's important to give the choice and the options available to both client and caregiver. Every aspect of my position here is to give them that choice, and then also the consequences of not receiving therapy; that's kind of best practice.

She later revealed how she involved family into a collaborative relationship.

> So together with the caregiver, what we do is we look at "What are the issues? What are the problems? What have you identified, as a caregiver, as a problem?" Next, we talk about "What have you tried? As a caregiver, what has worked, what hasn't worked?" Together, we negotiate and bring some other solutions to those problems, and then implement the action once we've decided on the goal and the plan of action.

However, collaborating with families is not without its challenges. For the occupational therapists interviewed, this involvement was surprisingly often spoken of in a negative manner. As Doug and Carla disclosed, "families are almost totally unpredictable" and "families…can be horrible to work with, just absolutely horrible. I mean, they walk on the unit, and you want to run. You know that you have to go talk to them, and they can be incredibly judgmental and incredibly abrasive, and actually, to the point that they're abusive to you." Challenges mentioned included communicating with family, elder abuse, differing opinions towards care of the older adult, and cognitive impairment in the caregiver.

> One of the challenges is with the families. Often family members are also elderly; when you have 100-year-old residents, their children are 80, and sometimes dealing with their needs they get a little bit confused, and we have to continually repeat things for them so that they understand what the care is that we're giving to their resident. [Emma]

Differing opinions and understandings by the family in comparison to the therapist was seen as challenging. Tanya shared the following, "Working with the families…can be really difficult, because they are sometimes looking for the cure, which we can't provide, especially when it's a dementia."

Participants talked of situations where various family members seemed to have differing opinions regarding the older client's care. As Doug stated, "Tough family conferences

are always when a couple disagrees and you are stuck there for hours watching two people argue over their mom or dad." This was echoed by Brittney

> There's always their children involved, so you often get involved in ...or observe some family dynamics; ... one brother wants the mother to go to a nursing home, the daughter wants her to go home, and the youngest son wants her to come live with them, and they're all having a squabble, and no one's listening to what the mother wants.

Carla shared that she had witnessed times when family members' had disregarded the clients' requests.

> You know, some of them respect their mother's or father's wishes, and try to make whatever happen, happen. Others will kind of railroad the parent into moving or going somewhere else, and then I hear about it, that the client isn't happy that they've had to move, like, say, to a lodge, or from their own place to an apartment. They say they've done it because their daughter or son has said that they wanted them to.

Tanya talked about experiences where the client had different opinions than both the occupational therapist and the family and how challenging that was for occupational therapist. She learned to listen to the residents and be their advocate. Tanya provided two examples.

> [One resident insisted,] "I just want to sit in my chair; I'm fine this way; I don't mind getting help. This is fine.... I'm winding down, and that's just how it is. I'm happy." [The resident is] happy doing it that way, but it was really hard for me to give her those little bits....Especially when you have a family that believes different than the resident, and the family is saying, "Why are you letting her do that? You should make her," or "You should be telling her she has to." And I think, "Yeah, I've become a lot stronger resident advocate than family." Not only just caving in to what the families want, and saying, "But your mom doesn't want that," or "Your dad doesn't want to do that, so why should they do it?"
>
> We've had several residents ... stop eating, and "I'm not eating any more," and families saying, "Do something! Give her thicker fluids. What's wrong with her?" and educate them it's not always about the fluid, it's not always about that they can't do it, it's they don't want to, and that we're not going to force them, and that we're not going to make them go on the crisis, they're not going to do these things if they don't want to, and helping families respect the wishes of that person.

Relationships played a crucial role in the experiences of working with older adults. Long term relationships with seniors, especially within the community, appeared to be prominent and cherished. The prominent issue with coworkers appeared to be strained relations with nursing. Clients' families also presented with some challenges as they often were seeking a cure for clients' health concerns that were no long curative. As well,

at times, they had opposing views from those of the client, with respect to care options and living situations.

2) Work Conditions

Employment settings. In listening to the experiences of the participants, there seemed to be different benefits and challenges to working in the various settings. There appeared to be a line that delineated the work sites into two groups: 1) larger institutional settings (including acute care and rehabilitation hospitals) and 2) community (including home care, public health and long term care facilities). Three key issues were revealed: access to resources, occupational therapy approaches, and autonomy and flexibility.

Hospital settings appeared to have better access to resources (e.g., peers for emotional support, experts within the same setting, in-house libraries). Community therapists tended to have fewer in-house resources for emotional support amongst their occupational therapy peers, along with fewer on site continuing education opportunities. As part of the consequences to having less accessible resources, there was a greater sense of isolation amongst participants in community settings, particularly in long term care facilities. As Brittney reflected on her earlier employment in long term care, "You're a brave soldier out there on your own at the front." Community therapists were creative in order to manage their isolation and lack of convenient resources. They not only sought supports within their smaller institution (e.g., rehab assistants) but also contacts external to their site (e.g., calling an expert in the rehabilitation hospital, relying more on information provided by vendors, developing a community networking group of

therapists working in long term care). These therapists also spoke more of completing self-directed studies.

When participants described the approach used in their occupational therapy practice, participants in all settings spoke of focusing on function and quality of life. This was corroborated with the written scenarios that participants provided where they focused on clients' independence and quality of life when they wrote of satisfying experiences.

Therapists also spoke and wrote of focusing on maintaining who the older adults were as individuals. Tanya provided a specific example.

> We have one lady [who is] very particular in her ways, very much cares about how she looks, very proper, very well-done makeup, very well-dressed, jewellery.... I think sometimes, working with older adults, we forget to maintain what they were. She very much needed to maintain that, as much as calling the front desk, where she would call our main line and then... just speak to whoever, and have us paged, and we'd come to the phone, and "You need to come to my room right now. I need to go" she'd say, "I need you to put my earrings on," or "I need you to get these particular shoes out of the closet," or "What is the program today, and what outfit do you think I should wear?" It took a lot of extra time, more than the other residents, but she appreciated it so much, and she wouldn't have come out to anything or she wouldn't have been involved...if we didn't maintain that for her. I think that as baby boomers come, they're going to

> have those same higher expectations. I just think that she was the epitome of treating someone with dignity, and our staff did a really good job.

At a closer glance, the approaches used when working with older adults appeared noticeably divided between settings. Within a hospital setting, participants identified restoring function and regaining independence as a primary focus. Brittney characterized many responses by stating

> The whole goal of the program is to get people back to gain their independence, increase their strength, and get them back to their previous home environment, whether that be a lodge, assisted living, or in their own home, independently.

Also within the hospital setting, the rehabilitation approach was prominent. But compared to other populations, as Carolyn stated, "Rehab takes longer with older people."

In contrast, within the community setting the focus seemed to be less on restoring and more of an emphasis on maximizing quality of life, keeping the client comfortable, maintaining current abilities, being client centered by listening and connecting with the clients, as well as end-of life care. Alison disclosed that at her work site it was more of an "end-of-life care kind of attitude, but it's still a very positive attitude, and it's giving the end of your life quality." Summer's comment reflected the sentiments of many, "I think it's more maintain, slow down, than rehab." Brittney echoed this sentiment.

> Long-term care, you're doing a lot of maintenance. People aren't getting better and they're not going home; that's kind of the end of the road when they're in long-term care, so most of the issues you're dealing with are quality of life. You're looking at helping people be comfortable, or preventing pressure sores, or looking at their seating for optimal seating.

With these community narratives comes the sense that rehabilitation, in the traditional sense, is not a primary priority. However, a couple of occupational therapists did express that some clients with whom they worked still had potential for improvement and rehabilitation.

There was a cautionary note to decreasing the emphasis on the rehabilitative approach with older adults. Emma had the analogy of a swinging pendulum with respect to people's perspectives on the importance of rehabilitation and older adults.

> I think it's like a pendulum… on one side, people are saying, "I want one hour of rehab a day," and as we slowly went to [a] new philosophy …that now we're getting to…"I don't have to walk if I don't want to," and "I don't have to get out of bed if I don't want to." So I think it's taken a swing to that side, and perhaps it'll come back to the centre. But it's been a big shift in focus … where families and residents are just, "I don't have to go to exercise group, and I can stay in bed all day and not participate."…. with this new focus, I have seen one resident who used to do her walking and who used to come to exercise classes because…she had a goal and she wanted to get better. But then people would kind of let her not

> go and say, "It's okay, you don't have to come, you don't have to do anything. We'll do it for you now that you're here in long-term care. We can push you around in the wheelchair."

The following story situated in a long term care facility and shared by Emma illustrated this belief.

> It…is a shame, actually, that a lot of care is … by somebody else. I know when I first assess them, that there are some people who can brush their own hair, brush their own teeth, and dress their upper body, and after a couple of weeks here, they stop doing that because someone else is doing it for them, and it's easier they say, "It's quicker and easier if I just comb their hair, if I just put on their clothes, or if we just use a lift rather than taking the time to get the transfer belt, stand them up, wait for them to pivot, transfer, and then to sit down again." So I think there's some learned helplessness. After a month of being here, many people do learn that "My shoulder isn't going to hurt as much if I just let her dress me."

This story has a clear message. When clients' activities are performed by someone else, there is the perception that decline is inevitable.

Interestingly, many participants, all of whom worked in the community, included within their written scenarios that they were disappointed in themselves for not being able to return a client to their former level of function or failed to prevent further deterioration in their client- a central tenet in the rehabilitation approach. Jane shared that progress isn't

seen nearly as often in her work setting as in the rehabilitation setting and "that's the downside" to working in long term care. Christina in home care shared, "I sometimes feel like I've failed them if I have to send them to a facility." Inferred from this is the fact that several occupational therapists continued to internalize, as primary expectations, the goal of restoring function and preventing further decline when gauging success when working with older adults.

Compared to hospital settings, there appeared to be increased autonomy and flexibility in work schedules within community settings. Linnea who worked in the community but also had worked within an institutional setting stated, "I have flexibility in my job, and I think that's key in the community… I didn't sense that flexibility as much working in hospital settings." Community participants reported that they typically scheduled their day in the manner that they wanted, with each day's set-up being different from the previous day. Emma, a long term care therapist shared a comment made by her manager, "You're the professional. You know more about OT than anyone else in the building, so you build the programs and you tell us what's appropriate." This flexibility and autonomy seemed to enable community therapists to report their job being less hectic and less stressful than therapists working in the traditional institutional settings. One therapist working in long term care made the following comment

> I have other OT friends that are in acute care… it's such a fast pace and everybody says they're there till 7 o'clock, charting, and they have to get it done because the person's going to be discharged. Here, it's a better pace. I think it's a more relaxed pace. It's still very busy; it's not like we're lazing around, but if you

don't get something done today, the person will still be there waiting for you tomorrow, kind of thing. So the pace, I think, is better. [Jane]

Perhaps to be expected, within hospital settings where many occupational therapists are performing similar job tasks to one another, it was common that programs were already set-up and appeared less flexible and more detailed with pre-defined goals and targets. There was talk of fitting into pre-existing programs, as opposed to creating entire new programs for the clients. However, some participants within institutional setting remarked that they too had autonomy and flexibility often in part due to understanding managers.

The range in autonomy and flexibility within different work settings appeared to be supported by the manner in which people came to participate in the study. The majority of earlier participants who volunteered worked in the community. Participants from hospital settings were more likely to be recruited only after a personalized invitation from a connection known mutually to both me and the participant. This may suggest an increased opportunity for community-based occupational therapists to take part in activities not outlined in their job description. Of these community-based therapists, participants typically chose to be interviewed during their work hours, suggesting increased flexibility during work and perhaps more relaxed workload pace. Participants based in traditional institutional settings typically selected either to participate in the interview during their lunch hour or outside of work hours.

Human resources. As is common in many occupational therapy settings, the lack of adequate staffing is experienced by occupational therapists working in gerontological settings. However, participants perceived that this population in particular was hit harder than others. Carla's comment substantiated this sentiment. "If you compare the caseloads in geriatrics to adults to paediatrics [in this facility], it's very different…..our caseload is basically double that of adults." Chris provided specific numbers. "You have to carry a greater caseload than most others… [In this hospital] in Adults most therapists usually see six to eight; I currently have 12 [in Geriatrics]. I [have] had 18 at one point in time." He expressed his thoughts on why there was such a discrepancy between staffing for different populations.

> I don't see it as being a priority with management. Management knows that we're chronically under funded and under staffed…. Maybe [they have] a stereotypical look at the elderly, that they're using more services and more time. It kind of gets my ire up… because it should be equal, right straight across the board.

The lack of human resources was perceived as a barrier to providing quality occupational therapy services to seniors. This appeared to contribute to increased workloads and decreased time spent with each client; and in turn affected how occupational therapists provided their services. This was exemplified by Emma.

> It's been challenging here because of the great caseload…there's just so many people to see … it's hard to keep on top of all the cases. Sometimes people do

fall into the cracks and they don't get seen for a while until they have some great need that I'm alerted to.

Participants expressed concern that they had little time to focus on the individual needs of older clients. Jane shared her frustrations.

> It is kind of disappointing, 'cause you know that had you more time, you could do more with these people. They're being gypped, and it also makes me feel like a bit of a flop as an OT, because there's this guy who needs the OT, and he's not getting it. Were he to go to some place else, they'd say, "Oh, the OT could have done that." Yeah, she could have, if she had the time!

Jane shared a conversation she had with another occupational therapist at her work site.

> It was so busy, we just said, "Look, just accept the referrals that come to you. Don't look for any." Because you'd walk down the hall and you'd see somebody flopped in their chair, sliding out…. "Unless it's referred, we don't have time to do anyone."

Comments were made regarding increases in caseload numbers over time leading to the increased demand for OT services. The following two comments reflected the experiences of many.

When I first started working [full-time], my caseload was 50, and clients were less dependent and less medically unstable than they are now. Now I look after 150 part-time, and yet they're a lot more dependent. [Alexandra]

The caseload was a little overwhelming, because it was 55 residents... I just thought that was a lot to manage at the time, but now I realize it wasn't, because now we have 136, and much more work. [Emma]

There are numerous ways in which individuals can respond to the lack of staffing and clients' limited access to occupational therapy services. It appeared that the customary response was that of changing expectations. Participants shared how it was important for them to change their perspective when working with such a large caseload.

What I do is I've learned to stop looking at the things that I didn't do or I can't do, or "I used to be able to do this." .... I don't do that any more; instead, I think, "What can I do for the person?" At the end of the day, I try to think, "What good things did I do for people today? What difference did I make?" That's how I end up enjoying my work, ... by looking at what went well, and trying not to look at what didn't go well or what I couldn't do. [Alexandra]

My thing is "Five minutes with an OT is better than none." So even though it is kind of hard I think with our model, there's so many things we could work on, and there's just not really time for that sometimes. So it's identifying concerns

> sometimes that you won't have the time to deal with, but then who can I refer to so it can get followed up on. [Alison]

The lack of adequate human resources and in turn large amounts of workload and decreased time spent with each client has lead to specific changes in practice amongst participants. Some occupational therapists modified or used alternative methods of service delivery. Two occupational therapists who had been practicing for 20 years reflected on such changes. Jane shared, "In the old days, you could actually work with somebody three times a week and here, you go, you consult, and you're gone." Alexandra shared the following

> I went from… we would run little stroke groups and education groups and family groups… and we would be able to do one-on-one treatment with almost everybody. Now it's not like that at all; we're very much quick assessment, quick consults.

In contrast to the majority, Tanya, who worked in long term care, commented on the fact that in her position she considered herself lucky as she still got to have one-on-one therapy interaction.

Non-human resources. While a lack of funding and services may be a concern with all populations, it is the perception of the majority of these participants that older adults seemed to be particularly hard hit. Alexandra commented on the particular lack of funds found amongst seniors.

> Funding often is more of an issue with older adults. I didn't have it as much when I worked with young adults. They often had insurance...when you get old, it's just your life savings and what the government's giving you. If you were lucky, you worked in a job where you had a good pension, [and] then you have a good income. But most of the people I see … are financially strapped.

Many of the participants' older clients seemed to have limited income, thus potentially benefiting from external sources of funding support. However, there seemed to be barriers associated with this supplementary funding. This comment by Linnea, who worked with seniors in the community, characterized many responses.

> They're low income. Sure, they get some benefits with the AADL[1] and with Blue Cross[2] but that puts them at a not-so-good starting point when they want to access other community resources, like, let's say an exercise program at this senior's centre, or buying health care products that aren't provided by the [government financial assistance program]. So they are at a disadvantage socio-economically.

Linnea explained the outcome for financially-limited seniors, who in turn, were unable to afford appropriate services and programs.

---

[1] AADL refers to Alberta Aids to Daily Living which provides financial assistance to people who have a chronic disability or illness, and those who are terminally ill, to gain access to authorized basic medical equipment and supplies so they can function more independently in a home or home-like setting.

> That puts them at risk for not getting their social fulfillment in their lives. Even food, some of the seniors that we see, they need to go to XXXX (name of drop-in centre) for their lunches, for hot meals.... and ... access the Food Bank.

She then discussed the disparity in her follow-ups between clients who are better off financially compared to those who are financially compromised.

> The seniors that I see who are living more affluently, who have more family support, there is better follow-up on, not only their part, but...my part, because I can actually follow up with their needs; they've got a phone, I can contact them. Some of the lower income seniors ... don't have a phone or ... don't contact me....or ...don't want to....At the XXXX (name of drop-in centre)... these are mostly men who, the majority of them don't have a phone, some of them are sharing accommodation, and they are dropping into that facility for their meals, for their lunches. So to do a...clinic there, it's hard for me to do any type of follow-up or monitoring, which is very key for a community therapist to do.

Many seniors face an additional financial burden when they realize that there are numerous unexpected expenses that are not covered by the health care system. Emma, who worked in a long term care facility explained

---

[2] Provincial health benefit plan

> They have to pay rent here, and it's about $1400 a month for a private room, and then when it comes to buying extras, like equipment that's not covered by [government financial assistance program]... like geri-chairs, for example... are not covered by the government. So ... the family has to either pitch in, or if there's no family, they have to really struggle to get that money together to get that equipment. I think with medical equipment being so expensive, and with all other things, they've got their ... creams and dentures and hearing aids and all that, and it's just so expensive, and I think the financial hardship would be great.

Along with the financial hardship and lack of financial support experienced by many seniors, there were several comments regarding the lack of services for seniors. One age group in particular appeared to be discriminated against. Linnea made specific reference to the cohort aged 55-65, a younger group on her caseload, and the gap in services for this group.

> We don't have anything to offer that age group, the 55 to 65. Once they turn 65, yay, they can access a whole bunch of resources and assessments.... So I really ... feel sorry for those who are 55 and over, or between 55 and 65, because they are at a disadvantage.

Hanna, who also worked in the community, shared these same concerns.

> The stunning thing that I keep coming up with when I'm dealing with my clients that aren't 65 is that there's actually almost a complete absence of supportive

programming for that group. There's no volunteer driver system for younger adults, people under age 65. Funding is extremely problematic for equipment, for drugs, for any of those services.... You've got volunteer driver systems, but they'll only take people 65 or up. XXXXX, XXXXX and XXXXX[3] ... they will only take people that are 65 or up. So what do I do with my 64-year-old?

Alison, an occupational therapist who worked in a community hospital in a smaller town outside the city, talked of the lack of services in her town and how this paucity lead to inappropriate placements after discharge. She talked of clients who were unsuitably placed in long term care facilities. These were clients who had the ability to live in the community if there had been funding for day programs and increased home care support. Later in the course of dialogue, she discussed how the issue of funded programs was even more severe in the rural townships smaller than hers.

In these communities, there's no middle ground; there's no assisted living, there's no day programs, there's no family group homes, and if they can't get into the lodge for a year, what are we going to do? We can't keep them in the hospital for a year to wait for a lodge bed.... in the country, getting Home Care to go in there, because they contract their services out from XXXX (name of big city) service providers. So... if they have to go and give someone a bath assist past [small town], then they have to pay the person to drive from XXXX (name of big city) to XXXX (name of small town) and back, plus the time in XXXX

3 These are specialized programs for older adults

(name of small town) that they're spending there. So it's hard for the people in the country even to get Home Care, because even if there was someone from XXXX (name of big city) willing to drive out to XXXX (name of small town), that's quite expensive to Home Care to have to pay all their travel costs and stuff. So I don't know; I guess the thing is decreased access to services in rural areas.

In her rural practice, Ana spoke of the delays in equipment trials. "Sometimes I'll get it the next week- a few days or a week. Other times, It could be… up to 3 weeks for a chair or a cushion." The decrease in services is a problem particularly for the frail older adults where time is often of the essence. In turn, they appear to suffer more from the sluggishness of the system.

Participants described other barriers to accessing adequate services for seniors. Long wait lists, which can be ineffectual for seniors who are palliative, along with inflexible regulations for seniors with ever changing health status were mentioned. Tanya provided a clinical example of the detrimental implications of having inflexible programming and funding that were unable to meet her clients' rapidly changing needs.

I was working with a senior with special wheelchair seating requirements. The resident needs were rapidly changing with an overall deterioration in function. Due to financial limitations of the family, and restrictions of government programs (AADL) and other hardship organizations, I was unable to meet the needs of this resident as quickly as they changed. She was often uncomfortable in her wheelchair and was very frustrated with her loss of ability to propel herself

in the wheelchair.... I felt that I failed the resident and that services did not work to provide the resident with the help that she needed. I was angry and became disillusioned with the systems available to my seniors.

Participants suggested that a lack of appropriate transportation services was a significant barrier for older adults and in turn impacted clients' ability to obtain health services and attend community programs. There was mention of some seniors' inability to pay for local transportation (e.g., bus or taxi), as well as the lack of physical assistance that some seniors required in order to transfer in and out of vehicles. Even when transportation was available, the length of time it took some older adult to prepare and get on the public transportation in order to attend a service was too much for clients who were frail. As Jane explained, "You might only have a 4-hour limit up in their chair, and then to spend an hour on DATS[4] getting there, and they're there for an hour and a half appointment, then come home, it's so much for them."

In addition to insufficient transportation programs, inadequate programs related to seating clinics was also a concern. One issue in particular was the long wait lists.

> It's about a 2-month wait list, you have to fill out quite a lengthy questionnaire to get this person over, and then they have to go there; ... it's an effort for them....our people are too frail to be trucking across town. [Jane]

[4] DATS is an acronym for Disabled Adult Transit Service which provides door-to-door public transportation for registered, pre-booked passengers 16 years of age or older who cannot use regular transit

> I feel their needs aren't met with the... programs we have.... The seating clinic is quite a long wait; 2-1/2 to 3 months, which doesn't suit my residents very well at all, because they change too much in that time frame. [Tanya]

To address the wait lists for seating clinics, which were often too long for frail seniors, therapists spoke of an array of solutions that they took upon themselves to solve in order to address seating challenges. Alexandra and Emma spoke of collaborating with vendors to gather information and decide on seating devices from which the client could benefit. Tanya relied more on her assistant.

> I'm really lucky that I have an assistant that is...very handy...[and] makes a lot of things....I'm usually...bargaining with people;..."We can make this for your mom if you'll pay for the raw materials of it. It will save you $100,"...Having a lot of courses on my side, it's mostly on seating, so in seating courses..., to try to learn ...(how to) us(e) the resource over the phone rather than sending my residents there, and finding out what they would do in the meantime. [Tanya]

While the majority of participants felt seniors in particular, received a lack of funding and service initiatives; Julie and Hanna, both home care occupational therapists, expressed contrary sentiments.

> I'm always amazed at how many things there are out there....We've got...quite a few programs for people that have low incomes for home adaptations, depending on the level of need that they have. You've got your Home Adaptation Program;

there's RAP[5], so if they're really low income, they may qualify for RAP if they're prepared to do all the work that's involved in getting access to that funding and prepared to wait it out, because sometimes there's time involved in that as well. There are special needs programs for seniors, where they can get some funding if they don't have enough money to pay for meds or yard work or that kind of thing. So there are quite a few things in place. [Julie]

Encouragingly, programs and services appeared to acknowledge the medical complexity of seniors as they seemed to use global criteria for access. In contrast, Hanna perceived that services for younger populations seemed to focus on a single diagnosis for the criteria for access.

> The stunning thing that I keep coming up with when I'm dealing with my clients that aren't 65 is that …, programming tends to be very [pause] diagnosis-specific. So you'd have to go to the Brain Injury Society, you'd have to go to the Parkinson's Society…. There's no sort of global organization that deals with gaps in the system.

With the gap in funding along with inadequate human and non human resources, there was a disparity between what participants ideally wanted to provide their clients and what they were currently providing. The lack of adequate resources was shaped by the third environmental influence- ageism.

---

[5] RAP refers to Resettlement Assistance Program which provides income support and a range of essential services to humanitarian cases for whom the federal government has undertaken financial responsibilities.

3) Ageism

Attitudes have a pervasive and subtle influence on all behaviours. Stereotypic attitudes regarding older adults' and their abilities had an impact on this older cohorts' experiences.

Societal. As the following excerpts revealed, ageist attitudes were commonly found throughout the general public.

> A [source] of dissatisfaction comes with others…that do not believe that seniors can make progress. I've heard and seen this attitude too many times to count with the laughs and snorts that I have been given following a goal that I (or my client) has come up with. [Ana]

> I think my biggest frustration is when people say that older adults are like working with kids, 'cause they're not like working with kids…. And we get that comment all the time…. family members will say, "I find my mom, it's just like I'm raising another child right now." They talk a lot about role reversal … yes, there is a role reversal, but she's still not your child and she still shouldn't be treated like a child….So that's …where people need to change their thoughts. It's like working with seniors, [laughs] it's not working with children. [Tanya]

Participants spoke of the energy they devoted into changing others' non-believing ageist attitudes in order to work towards a common goal and the satisfaction they received from this.

Even participants' older clients held ageist attitudes as Ana explained

> Sometimes older adults don't think they can do something, and they actually really can, so you sometimes have to push them a little bit. Then after they say, "Wow, I really can do that!" So I think sometimes they don't give themselves enough credit.

Within long term care there were specific references to older adults falling prey to the notion of learned helplessness. Seniors' made comments such as "I've gotten to this fine age and it's time somebody else do this" and "people are here to die. There's no chance for improvement".

There was the perception that ageist views even impacted funding allocation at the policy level. Summer shared the following insight

> There's not as much funding going into geriatrics. There is… the attitude that these people are at the end of their life, they've done it all, they're going to die soon anyway... And let's face it: people don't respond the same when you talk about an ill older person as they do if you show a poor little sick kid on TV in the ads. People will respond to that … they will donate, they will get behind lobbying for more funding; it's just very different, whereas you don't find that in geriatrics.

Hanna also shared that these ageist views lead to a lack of funding and disparaging

perceptions to a particular group - older adults with dementia.

> Folks that have a diagnosis of dementia aren't wanted anywhere; there's very few continuing care centres, there's very few assisted living facilities, there's very few lodges that will accept somebody with a diagnosis of dementia.

Brittney speculated on the source of these North American attitudes and stereotypes.

> There's different cultures that really value their elderly and they take pride in looking after the elderly, and that's their job, whereas I think our culture maybe doesn't, or our society doesn't have the elderly population at the top of the health care system. You might see a lot more programs for children that you would for seniors. Maybe it's the values… we value the young more than we do the old population.

Professional. Health professionals were not impervious to ageism. Participants spoke frequently of ageist attitudes that were pervasive amongst their fellow health professionals.

> Another disappointment may be colleagues' impressions that I landed a crappy job…. If it was a geriatrics job, and not a plastics, paediatrics or burns job, it wasn't glamorous or desirable. [Alison]

As mentioned some members of one specific health profession, nursing, were commonly

suggested by participants as holding negative attitudes to older adults. While not restricted to long term care, this setting was the most common location where nurses were referred to as holding negative attitudes. It is important to note that nurses are the predominant front-line profession with this population in LTC. Ana shared an interaction she had with nursing staff at the psychiatric hospital where she worked.

> I have my goals…and I might say to a [co-worker], "We're working on this." "Oh, you're never going to get them to do that." That's frustrating, because then you don't have the buy-in from the rest of the staff…. it's mainly from nursing, and I don't know exactly the reason why, but it makes it really hard to work as a team… and get things done. [pause] And it just makes it a really negative environment to work in…. So you just have to…stand your ground and…always remember you're working for the residents, and advocating for the residents…. So that's hard, because if you're dealing with other people who have negative attitudes, sometimes it kind of wears on you.

Ana suggested that it was a difference in perspectives that lead to this conflict. She spoke of nursing wanting to do more for the clients whereas occupational therapists want to help clients to learn to do activities independently

> [Nurses] are doers, and they're a little bit more task-orientated, I think. Their perspective is, "We need to help this person…" so they're going to tie their shoelaces or whatever it is that that person needs to be done, whereas OTs are looking at making that person independent. So that's how we help them... So it's

two opposite ways of thinking. [Ana]

Jane, who had also previously worked in a long term care facility, perceived that the nurses who worked in long term care facilities were older and of a different educational upbringing than the occupational therapists and nurses who worked in other settings. Alison shared that these older nurses often believed, "These people are dying anyway. We're making them comfortable." Julie, an experienced OT of more than twenty years, echoed these sentiments. Working in home care, her comments appeared to be founded in her relationship with nursing while she visited clients in long term care facilities.

> I guess there's probably a lack of experience with the individual that is dealing with that person, and yet, these are [nurses] that are probably as old as I am. One person said something … about this [client] not being a person who tries very hard, and sort of everybody feeds into it, instead of really looking at what's happening. I think there is a different mindset in some respects with nursing, as opposed to rehab, of actually getting the person to do what it is …you think they should be doing, and watching to see what happens. So that is probably one of my big frustrations.

Alison spoke of the challenges of having differing views and attitudes and approaching an issue between herself and some of the staff in a long term care facility where she had once worked.

Walking in the hall and hearing someone scream, "Nurse! Nurse! I need to go to the

toilet!" and then you'd hear, "Well, you have a pad on," ....they were a good group of nursing staff, but they were pretty stressed out. I guess maybe...you don't realize [pause] what saying something like that to someone can do. They just want to go to the bathroom; if you had a pad on, you wouldn't want to pee in it either, right? So that kind of thing...disheartened me.

Carolyn, an experienced occupational therapist of twenty years, spoke of her earlier position of working in long term care facilities. She perceived that nursing really wanted residents "to be as dependent as they could because of funding issues." The nursing manager had once said to her "if you make them better, we'll just get somebody who's so much worse." She went on to explain that this ageist attitude was not just isolated to long term care facilities. Currently working in acute care, she shared her frustrations with the attitudes of her nursing peers.

> I think that even in acute care, attitudes or expectations are different on geriatric people depending on what discipline you're in. And we always come from, "If you can do it, well, let's help you do it." Because I know they're short staffed sometimes, the nursing will say, "Well, I can do it for you. So much quicker. Let me do this." So that's a frustration.

Occupational therapy students were also perceived as holding these ageist attitudes. There was talk of students seeming disappointed in having a placement that was focused on older adults. Chris suggested that some students appeared to believe, "I have to do a geriatric rotation. Let's get it over with." Participants spoke of needing to ensure

students' experiences were extra special and that the placement could be positive. Jane in long term care shared "I saved my best people for them so that they had something interesting and hopefully they would see progress or feel some reward." This also once again demonstrated that progress or improvement was perceived as the ideal even within LTC settings.

The potential for gerontological occupational therapists to hold ageist attitudes themselves must not be overlooked. Several participants shared that at some point in their career, they held ageist attitudes. Comments included 'older adults are not candidates for rehabilitation'; 'older adults can not improve'; 'the older the person, the more frail they are'; and 'the older the person, the wiser they are'. Chris, an occupational therapist originally interested in working in acute neurology talked of his beliefs as a new graduate.

> That was stereotypical ageism, [chuckles].... [I] just figured there's not a lot of room to work with [older] people either orthopedically or neurologically. You know, there is a smaller window; they have decreased range in a lot of their joints and things. So it's just, like, "Well, would I be actually doing a greater service to somebody that's younger versus somebody that's older? Can I impact them more?" So that was kind of my thinking at the time. Little did I know that it could be an enriching experience working with these [older]people with the stories and their life histories.... that was an interesting eye-opener.

Not all stereotypes were negative. Tanya, who was a self-defined idealist, revealed that

she too had also held an ageist stereotype at the beginning of her work experience. However in contrast to the other participants, hers was a positive one. She disclosed, "I used to think that everyone was just nice like a little grandma or grandpa; that's changed a bit."

The existence of hierarchy within occupational therapy has on occasion been assumed but insufficiently researched. Participants revealed an elaborate system of professional hierarchy (i.e., some positions are accorded higher status) within occupational therapy practice. There was a noteworthy minority working in all different settings, who did not seem to share this notion of hierarchy and viewed themselves as an equal amongst occupational therapists working in other settings. As Carolyn who worked in acute care exclaimed, "I just think it depends on you. Like what your interest is….I know lots of OTs that only want to work in long-term care. And I know lots of OTs want to work in rehab." Jane, who worked in long term care, said that even though there may be a hierarchy, she noticed it less because she felt very competent in her position and that it was her decision to remain in her setting.

Of those who felt there was a hierarchy, participants talked of the positions that were accorded higher ranking using such terms as "glamourous", "romantic", "sexy" and "high profile." As Summer revealed, "I think I was like the majority of other people in my class, where I was going to get one of the glamour OT jobs, where I was going to be splinting and doing hand therapy." These 'higher profile' areas were seen by participants as receiving more funding. As Hanna, a home care occupational therapist, suggested, "The acute care system, they got the good toys. They've got the big buildings; they've

got the ribbon-cutting ceremonies. You can't open a ribbon to somebody's home."

Participants who referred to themselves as "working in geriatrics" perceived their own area to be relegated to lower ranks and being viewed as less intellectually savvy. Every participant who felt there was a hierarchy amongst the different populations, attributed the least power to working with older adults. This is exemplified in comments such as "not having a high profile", "being seen as less challenging" and "not as measurable." As Carla stated, "I think geriatrics is not perceived as a big-bang…romantic, flamboyant kind of area to specialize in." This is in contrast to other populations that participants viewed as being more revered. Summer shared "I think pediatrics is seen as a very exciting area to go into, that you're going to work with these cute little kids, and isn't it all going to be fun?"

Of those who felt there was a discrepancy amongst different work sites, acute care and rehabilitation hospitals were seen to have a higher ranking. Specific programs that were mentioned included: hand therapy, cardiac, paediatrics, orthopaedics, and neurology (e.g., spinal cord and brain injury). Long term care facilities seemed to be on the lower end and sub acute, home care and community programs were somewhere in between. Long term care facilities were often seen as being an undesirable place to work. As Emma who worked in long term care disclosed,

> I also have heard from other OTs and … somebody who helped me with my training, said to me, 'I think you're really wasting your potential.' She said, 'You're a really talented student, and I don't think you should stay there very

> long, because they're really wasting your potential.' I had to answer, 'I don't think so. I don't think you realize just how much there is to do there, and how stimulating it is.

She went on to share how she felt about this negative perception

> I used to just laugh it off and just kind of make a joke about it, but…it bothers me a little bit, because they have no idea what it's like…to think about 136 people every day that you're here, to just even remember all their names and all their needs. So yeah, I feel a bit like, in the therapy community, that we're not given the credit that we deserve.

Comments such as the following by Carolyn, in acute care and who earlier shared that she did not believe there was a hierarchy, demonstrated the possibility of such a hierarchy.

> What can you do with people in a nursing home? Whereas in a hospital … there's some kind of therapy that will make them maybe function a little bit better. But I think nursing homes have that thing of 'Oh, they're there and they'll finally die, what difference are you going to make?'

This was also evidenced by Daniel, working in acute care. He viewed that acute care was more challenging than home care. "I took a job that I thought I could do and home care…. It was pretty—I don't want to say easier, but in terms of the skill set it [required]

a little less instrumental skills. It was easier."

Hanna shared her perception of how home care was viewed by the acute care system.

> There is the lack of communication from the acute care system to us. In my opinion we're viewed of being kind of like the hillbilly Oklahoman who's married to his sister; you know, we're the backwoods cousin to the health care system....We're viewed as being kind of a dumping ground for people. We're the place where they can get people out of the hospital by promising them that we'll do all kinds of absurd things, just to get them out of the hospital: "Oh, yeah. No, no, no, we're not going to address that; home care will deal with that".... I think that what they think about the therapists in home care is that we couldn't make it in their system.

Alison, who worked in a small community hospital revealed her contentious sentiments towards the larger metropolitan rehabilitation hospital.

> We have had to work with some people that XXXXX [rehab hospital] wouldn't even touch. XXXXX [Rehab hospital] gets good results because they get people that have potential; it's the rest of us [laughs] that have to deal with these people that don't have potential. So there's always just a bit of contention, that sometimes they don't really think that us OTs in the little sticks are any good. Well, we don't get as good results; well, maybe we don't get as good a rehab potential client to work with, either, and we certainly don't have the resources

…to deal with some of the needs

Of those in acute care and rehabilitation hospitals who felt there was a hierarchy, the majority felt that within their own facility there also was a hierarchical pyramid. All of these participants believed that their settings (i.e., settings with primarily older adults) were relegated lower status, compared to other areas such as cardiac, neurology, etc. When participants working in acute and rehabilitation settings made comments related to the hierarchy of settings, including those external to their present work settings (e.g., home care, long term care, etc.) such as Brittney's comment "I think that… the bottom of the scale would be working in long-term care", several of them had cautionary comments such as, "That's not *my* view; that's just what I *think* it would possibly be." This may be a demonstration of the socially appropriate response, implying that they do not hold these views, but others around them do. Evidence of this appeared in the contradictory sentiments within Carolyn's interview. Early on in the interview she expressed "I loved rehab. I loved paediatrics. But… I think acute care is more challenging than any of those other things." However, when asked directly whether she felt there was a hierarchy amongst the different settings she recalled "I did hear … that acute care was…not better, but more challenging than working in rehab, but I don't think it's necessarily so. I think working in rehab is very challenging." Brittney, who worked in a rehabilitation setting shared, "Long-term care, you're doing a lot of maintenance. People aren't getting better and they're not going home….whereas in geriatric rehab, I find it a lot *more* rewarding" [italics added].

The stories of the participants appeared to reveal the existence of professional tensions;

not only with other health professionals and management but within the occupational therapy profession as well. When I asked participants what influenced their perceptions, they suggested that it came from: comments made from other colleagues; implicit messages sent from management; as well as the manner in which referrals were written. Here are a few examples

- An attitude of 'we decide, you carry it out'. Comments made by acute care occupational therapists to home care, as told by a home care occupational therapist, "Well you guys can look after equipment and we'll do treatment. So just follow up with what we've said in the hospital." [Christina]

- Alison, Carolyn, and Brittney noticed when colleagues were talking about where they want to work, they never mentioned geriatrics.

- Chris and Carla spoke of management within their facility not treating the different populations equally. They talked of how there was more equipment, smaller staff-to-client ratios for departments with younger populations.

- Alison and Brittney, both occupational therapists who moved from long term care to hospital settings received comments from occupational therapy colleagues such as "It must be much better than working in that [LTC] facility."

- Jane who had worked in long term care for the past twenty years shared her perceptions of how other OTs who worked with older adults pessimistically viewed working in long term care.

> You kind of get that impression… the people at the [rehabilitation hospital] kind of feel that they're a bit superior. And even acute care, they kind of look at us as, "Yeah, you guys, what do you do out there? We're rushing off our feet." Just in talking, you pick up vibes that they feel that … our jobs aren't as rewarding or we're not doing as much; maybe that we're not doing as much or making as much of an impact…. just the odd comment. I'm not even sure; maybe it was at a seating clinic or something, but just kind of assuming that we couldn't do things over here.

The existence of a professional hierarchy points to organizational complexity as an important feature hindering consultations and teamwork amongst health professionals. These participants provided the following recommendations for improving relations:

1) Increase communication;

2) Do not be condescending to fellow health professionals;

3) Compare hypotheses and findings between sites; and

4) Work together. For example, when approaching another health professional one participant suggested saying, "This is what we've seen and asking, 'What do you think?'." Working together means acknowledging that all participants bring equally valid knowledge and expertise from their professional and personal experience. Working together and thus reducing hierarchical dominance could energize people and encourage the contributions of all team members and thus enhance client care.

Attributes

The stories of the participants provided answers to 'What do gerontological occupational therapists consider as crucial attributes (i.e., knowledge, skills and attitudes) for practice when working with seniors?' Participants had little difficulty listing key attributes that they felt were important to enhance the provision of service within their scope of practice when working with older adults. The combined list of characteristics was long but the items fell into three major categories of skills, attitude and knowledge. Table 1 includes the list of attributes that emerged from participants' interviews. The attributes were invivo (i.e., direct words used by participants), thus not abstracted. It was important to keep the attributes in their original form to reflect the words of the participants.

Table 1

Key Attributes for Gerontological Occupational Therapists

Skills (observable)	Attitude (feeling about a person)	Knowledge
Observant (1,10,11, 13,16)	Positive Attitude (3, 4, 7, 8)	Wide variety of areas (3,4,7,8,9,11,12,14)
Active Listening (4, 5,7,9,10, 13,15)	Compassionate and empathetic (2,4, 7,9,12,15)	Diseases of the [illegible]
Solve issues (1,2,4,11)	Patient (4, 6,8,12, 13,9,10,11,14)	Normal aging [illegible]
Communication skills (1,2,5,6, 7,9,13)	Respectful (2,3, 5,6, 8,9,12)	Cognitive [illegible]
Counselling (6,9)	Nurturing (2, 3)	(6,9,11, 14)
Humour (3,15)	Confident (3)	Sexuality (9,14)
Make senior feel supported to maintain their dignity (6,7)	'Enjoy visiting and learning more about their stories' (5)	Dysphagia (4)
Synthesize info. And put into words (1)	Holistic (12)	Application and [illegible] assessment results (4)
Accept reciprocity (3)	Admit you don't know everything (14)	Community resources (1,4)
Leadership skills (1)	Non-judgmental (14)	How to adapt with [illegible]
Self-directed (6,13,14)	Genuine desire to connect with people (14)	Product awareness (1)
Flexible (3,9,14,15)	Extrovert (not an introvert) (14)	Quality of life issues (7)
Manage palliative patients (9,14)		Competence issues (9)
Good assessment skills (11)		End of life issues (9)
Problem solve together (12,13)		Medications (14)
Being able to look at more than one issue-multi-task (14)		Environmental modifications (3)
Explain and rationalize what you are doing for your client (14)		
Organized (15)		
Efficient with your time (15)		

*The number in parentheses represents the specific participant who mentioned the attribute. See Appendix G for participants' number code.

All participants included specific skills within their list of key attributes. One skill that was stressed significantly was communication. Jane voiced an insight that was echoed by others.

> Communication, I think, is the most important, because so many elderly people have English as a second language, they have hearing impairments, or they might have neurological conditions affecting their ability to understand, or Alzheimer's... So good clear communication is so important.

While all occupational therapists need to have good communication skills, to work with older adults participants perceived that this skill was particularly important. Participants expressed that the subtleties of communication required to work with older adults are extremely important. Doug spoke of requiring "flexible communication", being able to adapt to each client. Clinicians spoke of being astutely aware of the subtleties when engaging in active listening, speaking and observing older adults. Alexandra's comment expressed this perception of communication skills being more crucial when working with older adults than when working in some other areas.

> They need to have good communication skills, both written and verbal, which everybody does, but…there are areas where you could manage with [less communication skills]…you could get into splinting where somebody comes in with a particular problem, and you've got a referral that says do such-and-such a

splinting, and you look, and you go, "Oh, yeah," and a very quick little quiet explanation on what you're doing and how, and then you can quietly build.

Verbal communication strategies were suggested such as talking louder and more stressfully. Many participants spoke of acquiring a skill to tactfully redirect older clients who were being tangential and talkative. Participants spoke of making accommodations without being demeaning to their older clients, using simple terms to communicate the therapist's point, giving clear instructions, and avoiding medical jargon.

Participants also spoke of deliberately using nonverbal communication strategies. Time was viewed as an important consideration. There was talk of the importance of being patient as some older clients took more time to respond and share their ideas and concerns. Empathy and providing reassurance to the older clients who may need support or comfort, was also expressed. Linnea spoke of the importance of being empathetic and how she had gained this trait in her younger years.

> Working with caregivers… you need that empathy. I feel that I can offer that empathy, because even in my teenager years, I felt that I've taking a lot of care giving role in my family, high school as well, in having to help my grandmother out many times with her surgery, taking her to appointments and things like that. So I feel like I can really empathize with what the caregivers are going through….I've been told by the seniors I work with that they say, "You know what, [name], you're very good at your job." and they say, "You have a way of making us feel good about ourselves."

Listening was also viewed as an important nonverbal communication strategy. As Alexandra stated

> ....but I think with [older adults], you definitely need to have that skill....Just to be able to do that assessment, to get out of people...whether it's people being staff...the resident or the family, what it is that we need to do. When we get a request for x, is it x, is it y? ... to be able to differentiate that, you have to be more proactive in your communication skills. You can't just sit back and listen; you have to have some active interview skills to help them.

Alexandra's comments appeared to focus on needing to have listening skills that enabled one to delve deeper into an issue. This ability to delve deeper was voiced by many others as evidenced by such statements as Jane's, "the ability to understand people and know what they're *really* trying to say to you."

When participants were listing their ideas of key attributes, a comparison between data from experienced therapists aged 35 and older with the more recent graduates revealed differences in emphasis. Therapists of shorter tenure emphasized knowledge-based attributes as being essential when working with older adults. In contrast, experienced therapists emphasized skills and attitudes specific to interacting with clients as the key components required when working with older adults. Linnea shared, "You can have all the knowledge, the information about treating arthritis, about treating osteoporosis, about

dealing with chronic pain, about medication management, but unless you can deliver that in an effective way, the message won't get across."

Many participants perceived that there were some attributes that were inherent in some therapists' personalities that were appropriate for working with older adults. Often this was referred to as having 'the right attitude' as Tanya explained.

> Attitude is, I think, the biggest thing. I think you can gain knowledge on-site, you can gain skills, but if you don't have the right attitude, the residents will pick up on it right away, and you won't be able to build that rapport, and you won't get anywhere with them.

Jane provided an example of a therapist with whom she worked that seemed to be missing these inherent attributes.

> I was a supervisor of an OT department…and I had a girl there that, on her resume, was fabulous….For her part-time job she worked with this guy who had a stroke…as an aid to him. She was a member of the Arthritis Society; all this stuff! I was, "Wow, this girl is *skilled*!" And she had all the knowledge, she was super, but she didn't have — she couldn't communicate with the elderly. It wasn't an accent or anything; she had no accent, but it was… her attitude; she was … condescending and told people what to do, and just didn't have compassion. When she left — she was with us 9 horrible months [laughs] — she had offended most of the staff in the place, and even the residents were saying, "Oh, thank

> goodness she's gone." .... It was after that that I realized that there are skills that you can learn ... but there's some things that are in you, the compassion, the empathy, and the communication, the ability to understand people and know what they're really trying to say to you.... But you can learn anything about the strokes and the meal observations and equipment.

A specific type of personality was mentioned that appeared to be an ideal match when working with this population. Alison shared, "I feel that my personality's a bit better suited to working with geriatrics." She spoke of the ideal type of OT to work with older adults as being "someone... who enjoys visiting with people and learning a little bit more about their stories."

Therapists did not limit themselves to the skills, attitudes, and knowledge listed above. They also described attributes that would be difficult to categorize in a list, such as Linnea's comment of "making someone feel purposeful in life...that it's okay if they make mistakes, it's okay to ask for help, and just a lot of encouragement."

While participants revealed a wide array of attributes, the ones that were emphasized the most were communication skills as well as being compassionate and empathetic.

Gerontological Pearls – Participants' Advice for Working with Older Adults

Along with the list of attributes, therapists shared their clinical wisdom and insight into important concepts and ideas they learned while working with older adults. Here are some key strategies to working with older adults.

- Everybody is unique and treat them as an individual. Don't take for granted that an 85 year old has more health problems than a 60 year old.

- Older adults have lost so much, and they need a bit more compassion and understanding than somebody who's just briefly sick or is going to get better. They need to be understood and nurtured more than the other population.

- Since they tend to have more disabilities than the younger populations, it is even more crucial to focus on their strengths rather than the limitations. Focusing on their disabilities is such a negative experience. They like to hear about what they can do, not what they can't do.

- Be aware that older adults have a life history and discover it. Knowing a clients' life story, can change the quality of the relationship dramatically between the health professional and the client.

- They are a more 'seasoned' problem-solver with challenges encountered in life. They probably have used many creative approaches to dealing with what life's

problems.

- Seniors themselves don't identify themselves as stressful beings: "Why should we be stressed? We have all this time, we don't work; what could we possibly be stressed over?" And yet when you talk to them, they have numerous stressful issues; physical health, mental health, family concerns about their children. Some of these seniors are outliving their children, so they're grieving.

- There is a preconceived notion that seniors in the community need a lot of help, are weak, are very frail, and are losing their minds. Actually it's the minority that fits that description.

- Be prepared to become quite attached to the clients you work with.

- When they do pass away or when they get sick, you can go through emotional ups and downs.

- Be prepared to really listen because sometimes seniors will tell you what they think you want to hear, but that's not what they really want. For example, the family really wants the older adults to move, so the seniors are saying, "Okay, I'll move," but really, they don't want to.

- Show respect for your older clients when addressing them. Seniors do not like to

be called 'dear' (e.g., "Oh, dear, you'll be fine," or "If you just do this, dear").

- Never take anything for granted. Never make any assumptions about anybody. Never assume that just because they're older they can't do this or they can do this. You have to find out.

- You can do the smallest thing for an elderly person and make a huge impact on their life. Anything from doing a home visit and putting in some equipment in their bathroom to give them back their independence and confidence in using the bathroom by themselves, little things like that will make such a huge difference. It might keep them in their home for 5 more years.

Career Plans

I asked each of the therapists if he or she planned to remain working with older adults and why or why not. The responses varied. The majority of participants declared that they certainly planned to remain working with older adults. As Tanya exclaimed, "I definitely see myself working in geriatrics, probably continuing in long-term care, 'cause I really like it." Similarly, Brittney affirmed, "I find this field very challenging and interesting, and I love it, so I'll still be in geriatrics." Of these, several commented on perhaps moving in the later future into the teaching roles or upper management but still within services for older adults.

Two therapists, both newer graduates, indicated they were looking to move on to

different work settings which in turn may or may not include older adults. Both expressed that they felt a need for change to gain further experience.

> I've thought in the past little bit of wanting to continue on in my schooling and doing my master's....And in the next little while, I would like to get some different experiences, such as some acute care experience, some experience with children, maybe some specialty experience, like hand therapy. But I really don't know, and I haven't decided which way I want to go yet. [Ana]

> I see myself working in a different setting. I think 3 years is about enough for me....not because I don't like this type of work, but I just want to learn something else.... So probably I'd hope to see myself working in another country or city in Canada. I'd like to see myself doing work focused on maybe out-patient care in the community, or maybe even acute care, but more clinical skills....I think I'd still work with adults....over 18 and geriatrics again probably, if the opportunity came up. [Emma]

Only one experienced occupational therapist indicated that she was considering leaving her work with older adults. She explained that this was a possibility due to the poor therapist-to-older adult staffing ratios in her work setting, requiring long work hours and increased stress. She thought that she may go into paediatrics where the staffing ratios are smaller and there are longer vacation breaks.

Summary of Results

This chapter presented the findings from 16 participants who shared their stories about working with older adults. This included an examination of the experiences of being a gerontological occupational therapist; as well as exploring attributes that gerontological occupational therapists consider for practice when working with seniors. The qualitative research approach of interpretive description was used to examine the experiences of gerontological occupational therapists.

The occupational therapists in this study expressed that working with older adults was enjoyable, inspiring and rewarding. What made working with older adults so powerful? Participants expressed that the positive aspects to working with older adults far outweighed the negative aspects. Participants spoke of the joy it gave them to help this population. They talked of their older clients having made it through so many hurdles and obstacles. Even doing something as simple as giving a client a bath seat could improve their quality of life in a meaningful manner. Participants reported being driven by the challenging nature of the older adults' complex health issues. The medical complexity of older clients, along with their particular life stage and unique cohort traits made participants' experiences particularly distinctive compared to working with younger populations. External environmental influences (i.e., interpersonal relationships, work conditions, and ageism) also appeared to play a factor on the experiences of the gerontological occupational therapists. In today's health care climate, gerontological occupational therapists are still confronting ageism and work conditions. Participants spoke of a discrepancy in working conditions for older adults compared to younger

populations. The results also showed delineation in experiences between hospital-based therapists and community based therapists. Participants acknowledged a number of important attributes including flexible communication skills and having 'the right attitude'- being empathetic, compassionate, enjoy visiting and listening to the stories of their older clients. Participants provided examples demonstrating the uniqueness in their experiences. Where appropriate, examples were provided of how their experiences differed from those of therapists in other realms. The participants and the themes and concepts that came from their stories provide valuable insight into what it is actually like to work with older adults.

CHAPTER FIVE: GERONTOLOGICAL OCCUPATIONAL THERAPISTS AS SPECIALIZED GENERALISTS

Unless an occupational therapist is working strictly in pediatrics or adolescents, virtually all therapists will be working with older adults or clients with aging family members. Yet, there is very little empirical research or theory focusing on the experiences of occupational therapists working with older adults. Much of the literature regarding working with older adults is anecdotal, based on opinions of authors. This study examined perceptions and meanings of practice as described by 16 gerontological occupational therapists. These data can inform educators in entry-level programs, as well as occupational therapists who seek to progress within this specialty. The previous chapter described findings of two specific research questions: 1) how do occupational therapists describe their experiences of being a gerontological occupational therapist? and 2) what attributes (i.e., knowledge, skills and attitudes) do gerontological occupational therapists consider crucial for practice with seniors?

The data in this study suggest that the experiences of being gerontological occupational therapists were positive; however there were obstacles. The commonly held belief that working with older adults is viewed as sombre and morbid was dispelled. Participants described their experiences as enjoyable; offering variety, intellectual challenge and satisfaction, while recognizing that there were negative aspects. The most predominant negative aspect was the ageism that appeared to influence participants' abilities to feel that their work with this population was valued.

The image that best portrayed participants and their shared experiences was that they felt like they were both generalists and specialists. Gerontological occupational therapists' experiences were reported to be more complex and contradictory in practice than the literature indicated. Participants spoke of their older clients as being multifaceted and not behaving in a predictable and straight forward fashion. Occupational therapists working with older adults expressed a need to have a wide breadth of knowledge, as well as in-depth and specialized knowledge on the complexities of care and co-morbidities. No gerontological occupational therapy literature was found describing this dual persona.

I begin this chapter by examining the influential presence of ageism within the experiences of gerontological occupational therapy. Following this, there is a discussion of key attributes and then the debate is presented between whether these professionals are viewed as generalists or specialists. Limitations of the findings and implications for this study are then outlined. Following this, changes experienced by the researcher are listed and then a summary of the study is provided.

Ageism

Discussion on the impact of the aging population on social structures, including health care, has been present since the 1960s. Along with this, talks regarding the presence of ageism and the need to eliminate negative stereotypes and attitudes related to aging have been emphasized. Many positive influences have occurred since then. The literature suggests that misconceptions about aging are declining (e.g., Butler, 2005; Grant, 1996) and gerontologists predicted that the twenty-first century would be an era of positive aging (Katz, 2001). Moneys invested into health care continue to rise (Canadian Institute

for Health Information, 2005). Aging research has proliferated, including the effectiveness of occupational therapy with older adults (Foti, 1996). There has also been increasing amounts of gerontological content within occupational therapy curricula (Klein, 2002; Stone & Mertens, 1991). Age discrimination appears to be less common.

Despite these positive influences, this study revealed that there remains covert discrimination towards older adults, the therapists with whom they work, and the organizational structures related to this population. Ageism seemed to be at the root of the majority of challenges faced by participants and appeared to impact their perception of being fully valued within the work setting. Unlike other stereotypical attitudes such as racism and sexism, ageism appears to still be deemed socially acceptable, as evidenced by its pervasiveness within the present-day experiences of gerontological occupational therapists. It is a form of oppression that seems to be so ordinary it raises few concerns.

In order to better understand the presence of ageism when examining gerontological occupational therapy issues, the perspective provided from a social model can reveal a broad contextual standpoint. Social models contrast traditional views of aging including the medical model perspective portraying older adults as a medical burden. The social model perspective enables one to look beyond older adults and the impairments they may have, and focus on a set of causes established externally.

Social theories are helpful to explain the general phenomenon of aging (e.g., social exchange theory, Dowd , 1975; modernization theory, Burgess, 1960; activity theory, Lemon, Bengston and Peterson, 1972; ecological model of aging, Lawton and Nahemow,

1973). However, it is also beneficial to examine concepts from the social models of disability to provide a more comprehensive perspective regarding the experiences of gerontological occupational therapy and the older clients with whom they work. Social models of disabilities argue that a person does not *have* a disability, a person *experiences* disability (Putnam, 2002). This perspective argues that disability is not inherently a part of the person, but rather a function of the interaction between the person and environment (Barnes et al., 1999; Putnam, 2002). Thus, it could be argued that environmental barriers (e.g., inadequate resources and personnel) are acknowledged as playing key roles in increasing the challenges of working in gerontological occupational therapy and in turn enabling occupation for older adults.

Many parallels can be drawn between older adults as a social group and the disabled community. Disability, like aging, typically can not be cured, it is to be 'cared for' (Oldman, 2002). Older adults as well as those who are disabled have often been treated within North America as lower forms of life- 'the other' (ibid.,), as evidenced by the ageist and ableist perspectives within society. While individuals with disabilities have suffered considerable discrimination, they have had some success in lessening the effects (Barnes, Mercer, & Shakespeare, 1999). Older adults and those who work with them can learn from social models of disabilities and the social movement they have produced.

There are several social models of disability. One is Oliver's social model of disability (1990) that draws on Marxist analysis to explain oppression of disabled people within capitalist societies. Disabled people are seen as a burden since they are often viewed as being unable to be as economically productive as non-disabled people. This can be

ascribed to older adults as well. Hahn's (1994) 'minority group of disability' theory proposed social attitudes to be the root cause of disability. Within the current study, it has been argued that it is not the older adults who appear to be the root of the negative experiences, it is ageism. A merge of the concepts of social models of aging along with disability models provides a more comprehensive perspective when examining the experiences of gerontological occupational therapists. It acknowledges the structural barrier of ageism and helps to explain ageism and why health professionals and others sometimes appear to hold negative attitudes and behave in negative ways with older adults. It also allows for the opportunity to examine the positive aspects of working with older adults even though therapists have experienced and witnessed ageism throughout their work experiences.

I would argue that ageism is socially produced in response to influences of powerful discourses including 'rehabilitation' and 'independence', as well as public and professional attitudes. These social productions in turn impact service allocation, social structures and older adults' persona.

Ageist Discourses

One way that ageism has been socially produced is through the promotion of the powerful discourses of rehabilitation and independence within the health care system at large and in particular, occupational therapy practice. These discourses have placed a high value on abilities and function and in turn, created a fear of dependence and deterioration. The discourses of rehabilitation and independence perpetuate the notion

that older adults who are unable to remain disease-free and live independently in the community are viewed as a burden to society.

The Meaning of Rehabilitation

"When I use a word, it means just what I choose it to mean"

-Humpty Dumpty says to Alice in Lewis Carroll's (1872/1997) Through the Looking Glass Chapter 6 (p.113)

The term rehabilitation is defined in the Oxford English Dictionary (1989) as "restoration (of a disabled person, a criminal, etc.) to some degree of normal life by appropriate training". In Webster's Unabridged Dictionary (2002), the term is described in the following manner, "the physical restoration of a sick or disabled person by therapeutic measures and reeducation to participation in the activities of a normal life within the limitations of his physical disability". Wainapel (1999) defined rehabilitation medicine as being "concerned with restoration of lost function to people with musculoskeletal, neurological, or many other physical disability" (p.55). Fordyce's (1999) geriatric reference book included a focus on rehabilitation. In it she described the goal of geriatric rehabilitation to "return to as a high a level of function as possible." (p.129). She continues, "A good rehabilitation team will try to halt the downward spiral…to keep working at restoring function" (p. 130). As evidenced by the aforementioned definitions, the term 'rehabilitation' is traditionally equated with restoration and the standard of restoration is to 'normal'.

Conflicting Messages

The term 'rehabilitation' describes only one aspect of the entire scope of occupational therapy practice. In addition to restoring function, the scope of occupational therapy has broadened over the decades to include functional goals, family context, and client autonomy (Hasselkus, 1989b). As well, there is an emphasis on promoting the occupational needs of individuals and maximizing quality of life, even when a client is dying (CAOT, 2005b).

This shift in perspective, though often explored in publications, was not as evident in occupational therapy practice. When speaking of the rewards and negative aspects of working with older adults, participants often spoke about their experiences from a rehabilitation framework. They spoke of it being hard to accept deterioration in the health of their older clients. Therapists reported wanting to restore their clients to previous abilities. They spoke of sometimes being dissatisfied and/or disappointed when this was not achieved. Many of the occupational therapists in this study still considered the goals of restoring function, and achieving independence as ideal goals, in other words, 'rehabilitation equals success'. Some participants also appeared to equate quality of life with independence and restoration of pre-morbid abilities. This is evidenced by the fact that when participants spoke or wrote about a situation where they felt dissatisfied as an occupational therapist many of them described situations where they were unable to prevent further deterioration or improve function. It might be that these goals set occupational therapists up for disappointment because, at times, they are unrealistic goals when one works with older individuals, particularly those who are frail. Gerontological occupational therapists appear to be reflecting societal expectations and perhaps playing an important part in perpetuating their own problem.

My argument that participants tended to overemphasize the restoration of function and the discourses of rehabilitation and independence is also consistent with, and perpetuated by, the philosophy of the professional occupational therapy associations in North America. On the AOTA website the definition of the profession is currently defined as "Occupational therapy is skilled treatment that helps individuals *achieve independence* in *all facets of their lives*. It gives people the "skills for the job of living" necessary for *independent and satisfying lives*. Services typically include: Customized treatment programs to *improve* one's ability to perform daily activities …" (italics added) (As retrieved by American Occupational Therapy Organization, May 16th, 2005 www.aota.org). From the CAOT website: "Occupational therapy provides the skills for the job of living to help people lead productive and satisfying lives….An occupational therapist may help you *overcome* your disability by:…Educating or instructing you on how to do things with the abilities you have…. And suggesting activities that will help you *improve or maintain* the abilities you have or are weak in" (italics added). (As retrieved by Canadian Association of Occupational Therapists, May 16, 2005 www.caot.ca). The importance of restoring function is even emphasized at the funding level for Medicare. Currently the reimbursement for rehabilitation services, including occupational therapy, is consistently tied to the rehabilitative approach and reducing impairments and improving function (e.g., Department of Justice, 2005; Health Canada, 2006). The aim of this reimbursement focus is "*increasing* an individuals' likelihood of being an accountable, productive societal member or of reducing costs associated with necessary care" (Kielhofner, 2005a, p.489).

The term 'rehabilitation' fits neatly within the medical model, where conditions are treated and cured, thus emphasizing restoration and rehabilitation (Imrie, 1997). However, many once fatal conditions have become chronic in nature, driving care towards chronic illness management. This requires a shift in intervention outcomes that has not yet completely occurred within health care, including occupational therapy. Clearly there is a mismatch of ideologies between the traditional rehabilitation approach and approaches required to work with older adults (ibid).

Naturally, occupational therapists are attracted to the profession because they want to help others. Their *raison d'être,* at least one of them, is to prevent functional decline in their clients. As Alison, one of the participants, said. "I think part of the OT personality, we like to help and so when something's not working out… it's a bit more dissatisfying to us." While this focus is certainly suitable for many populations with whom occupational therapists work, it is not realistic when one is working with certain populations of older adults (e.g., frail seniors, palliative seniors).

Incongruence between Independence and Respect for Client Choices

It has been argued that one of the biggest 'ruts' that the occupational therapy profession has fallen into is the notion that attaining personal independence is our central belief (Wilcock, 1998). Indeed the act of enabling older clients to go home was viewed by therapists as an accomplishment "par excellence" (Hasselkus et al., 1997, p.133). There is an assumption within occupational therapy practice that independence in daily activities is the ideal goal for most clients, whereas this is not always realistic.

This emphasis of independence appears to be ubiquitous. Tornstam (1992) argued that due to deeply entrenched value patterns in Western society, ageism is ever present and characterized in part by this strong emphasis on independence. The medical model portrays older adults as a medical burden, in part because they are at risk of becoming dependent (Imrie, 1997). Even contemporary aging theories such as Rowe and Kahn's 'Successful Aging' (1998) emphasize independence as a crucial attribute. They state that successful aging "can be attained through individual choice and effort" (Rowe &Kahn, 1998, p. 37). Thus, there is a focus on individual behaviour, and older adults being responsible for their own health and well-being.

The promotion of the independence discourse within occupational therapy practice can create a struggle for occupational therapists when respecting client choices. Participants in this study (e.g., Tanya, Chris and Julie) spoke of this dissonance and acknowledged it was sometimes difficult to accept that some clients chose to have decreased mobility and have someone else complete important tasks, in contrast to obtaining independence to perform an activity. The recognition of an individual's right to self-determination (Bye, 1998), can be particularly difficult when an older individual is frail. It is possible for a frail older adult living in a long term care facility to prefer having an attendant complete her activities of daily living such as dressing and bathing, and being wheeled to the dining room instead of seeing an occupational therapist for weeks to try to regain independence in these areas. This decision should not be viewed as a failure, but as respecting the wishes of clients and believing that this is improving their quality of life. By valuing and emphasizing rehabilitation and independence, therapists will not be as open to understanding what patients' goals are if they differ in any substantial way from

what therapists had in mind, which in turn leads to a failure to develop true partnerships. Finlay (2001) described holism as 'a badge' that occupational therapists use to convince others of the value in what they do, without questioning the extent to which their own practice actually reflects that ideal. The same may be said of respecting client choices. This mismatch between therapist and client-driven goals was explored in Rosa's (2002) doctoral research. She argued some occupational therapists took for granted that their notion of what was best for their clients was a 'good choice'. Rosa suggested occupational therapists tried to convince their clients to come around to their way of thinking.

When occupational therapists do not negotiate or abide by a client's preference for an individual goal, this could be a manifestation of ageism. A truly holistic and client-centered approach would be to consider that the energy saved in performing self-care activities could allow the client to be alert and enjoy visits with his or her family. Sometimes important clinical outcomes must be sacrificed to preserve others (Bye, 1998; Reuben, 2004). Client preferences can lead to individual outcomes that differ from those we desire for a population.

Ageist Attitudes in our own Backyard

One of the most significant factors influencing participants' experiences was the environmental barrier of attitudes and perceptions of others. Participants revealed they had experienced a significant number of incidences related to ageism stemming from comments made by friends, older clients, other health professionals and occupational therapy colleagues. This was consistent with literature that described work with seniors

to be devalued and assigned low status (Arino-Blasco, Tadd, & Boix-Ferrer, 2005; Horowitz & Bressler, 2000). Wesley (2005) reported that the public still stigmatized working with older adults; viewing this work as less creative, less challenging and less satisfactory than work with other populations. Research with nurses and physicians revealed that health professionals held ageist stereotypes and attitudes towards their older clients (e.g., Gunderson, Tomkowiak, Menachemi, & Brooks, 2005; Lookinland & Anson, 1995; Madan, Aliabadi-Wahle, & Beech, 2001; Palmore, 1999).

Regarding occupational therapists in particular, studies suggested that when compared to other health professionals, this group and their students were not as influenced by societal negative attitudes with regard to clinical decision making and appeared to hold more positive attitudes (e.g., Giles, Paterson, Butler, & Stewart, 2002; Horowitz, Savino, & Krauss 1999; Todd et al., 1987). Nevertheless, my study revealed that ageism was present within the occupational therapy profession and possibly therapists were playing a part in perpetuating their own problem. Occupational therapists appeared to be agents of ageism - reflecting societal expectations and reinforcing stereotypical tendencies that were already present in society. This difference in findings may be due to Palmore's (1999) suggestion that while people's remarks may be positive, negative values are often still held, so it may be difficult for individuals to admit to ageism. Participants perceived a lack of understanding amongst their peers regarding the complexity of care and about the level of knowledge and skill required to meet the needs of older adults. Ageism was even reported amongst participants themselves such as Chris' earlier belief that compared to younger adults, older adults were not as worthy of rehabilitation services.

If ageist views are held by occupational therapists, it is likely to have an impact on entry-level students. Taylor and Tovin (2000) reported that poor attitudes of clinical educators can negatively impact their students' attitudes towards working with older adults. Evidence for such ageist views amongst clinical educators was demonstrated by Emma's story. After she had told a clinical educator that she was working in a facility with older adults, the clinical educator replied, "You're a really talented student, and I don't think you should stay there very long, because they're really wasting your potential." Participants reported that various students appeared less interested in doing placements with older adults. According to Wilkins and Rosenthal (2001), students frequently are not keen to pursue opportunities to work with older adults.

The societal view that work with older adults is depressing and centering around death (Cruikshank, 2003; Palmore, 1999) was challenged in this study. Although participants spoke of end-of-life issues and death, surprisingly most of this referred to others' perceptions. Participants themselves did not communicate personal preoccupations with fearing death, although certainly they must have encountered end-of-life issues routinely. Participants spoke in neutral terms with respect to their own views on death. They appeared to accept the end-of-life stage of their clients and could be described as viewing this stage of aging as 'necessary losses' (Viorst, 2002). This acceptance is consistent with the suggestion that occupational therapists who worked with seniors value the 'here and now' and "accept[ed] the older clients' movement toward death" (Hasselkus et al., 1997, p.139). Indeed, in one study, occupational therapists working in palliative care viewed death as a natural part of life (Prochnau et al., 2003). It is conceivable that once occupational therapists in this study began working with clients who were closer to

death, they made a 'conceptual shift' in their thinking regarding death as described by Bye (1998). This reconceptualization serves the purpose of helping therapists cope with the sense of defeat by the deterioration and sometimes eventual death of their older clients. Participants spoke of the fact that amid their losses, there were positive aspects (e.g., increased awareness of compassion and change in personal outlook in life) and similar to Bye's (1998) and Prochnau et al., (2003) participants, they saw value in the individuals' remaining life. Bye characterized this outlook as affirming life, preparing for death. This conceptual shift was also observed among physicians, where Adams et al., (2002) suggested that this adjustment may not be able to be made by all physicians. Possibly, if given a choice, occupational therapists who were not comfortable with this adjustment may choose not to work with older adults.

In the literature, a number of barriers to working with older adults was identified. These include a perception of limited interaction within the professional team, narrow scope of experiences, lower salaries, and a belief that extended time spent working in gerontology would lessen their ability to get future promotions (e.g., Coren et al., 1987; Dunkle & Hyde, 1995; Wilkins & Rosenthal, 2001). In contrast, participants in this study did not report any of these perceived barriers as being actual issues faced in their work. Instead, they spoke of having significant interaction with other team members, a broad scope of work experiences and they held the view that career doors would open (e.g., opportunities to move into academic and upper management roles).

Positive Ageism

Participants in general, thought that with aging comes wisdom and they provided examples from their experiences. It is an encouraging sign that occupational therapists associate older adults with such an admirable trait. However, there is a lack of consensus regarding the relationship between wisdom and age (Sternberg, 2005). Wisdom is dependent not so much on age but influenced more so by cognitive variables, personality variables and life experiences (ibid, 2005). Several participants clarified that it wasn't *all* older adults who are wise but the *majority*. However, when general comments are made about this population being 'extremely wise', there is a risk of approaching an elderly client with an initial assumption that their older clients possess a degree of wisdom. Caution must be taken as this perception may paint older adults in an overly positive manner, also known as *positive ageism* (Palmore, 1999). Although positive ageism is usually far less damaging than negative ageism, it is still based on inaccurate information that reinforces an unrealistic distorted view of older adults (Palmore, 1999). Other positive stereotypes include viewing older adults as healthy, happy and financially secure.

Positive ageism may be an issue particularly within the occupational therapy profession. A study on ageism comparing physiotherapy and occupational therapy students and clinical educators found significantly higher positive bias scores by occupational therapy students and clinical educators compared to those within physiotherapy (Giles et al., 2002). While they do not propose any suggestions as to why this is, Horowitz et al., (1999) suggested that occupational therapists are inherently optimistic regarding all

populations, and therefore, have high expectations for their clients irrespective of age. Another possibility is that participants in this study, along with others in the aforementioned studies, were aware of the socially appropriate response to make. Perhaps they were focused on increasing awareness of the positive aspects of aging in order to compensate for embedded negative stereotypes.

The impact of this positive ageist stereotype on the occupational therapist-client relationship can be significant. If a therapist perceives her older clients to be wise, the occupational therapist may accept more of the clients' discussions and opinions without question. In addition, the therapist may not be as apt to discern if someone is coping with early signs of dementia. An assumption may be made that an older client understands the therapist's directions and explanations. This ageist perception may place undue pressure and decrease self-confidence on older adults if they are not able to remember or understand something that they are being told. This could potentially increase risk of depression and low self-worth in some older adults.

Social Impact of Discourses and Ageist Attitudes

The discourses and ageist attitudes embedded within society, the health care system, and occupational therapy practice have several implications. The gerontological occupational therapists spoke of discrepancies in service allocation, presence of social hierarchies, and personality traits unique to the older adult population.

Service Allocation

According to participants there were discrepancies in funding, staffing, and service allocation between older adults and younger populations. Participants perceived this lack of resources as impacting the quality of services provided to seniors. There was a perception that the health care system was not supporting the current needs of older adults and less so when compared to younger populations. Indeed, a review of staffing ratios from a local hospital showed that occupational therapists working with older adults in that hospital had double the caseload than those who worked with younger adults (G. Maier, personal communications, April 16th, 2006). As well, there was one research position focusing on the issues of younger adults, however, there was no such research position dedicated to older adult clinical questions.

Many participants felt this discrepancy was due to ageist stereotypes held by management and other key decision makers in their organization. This is evidenced within Canadian health care. When the Canadian Senate Committee on Social Affairs met to examine the state of the health care system in Canada, one invited expert, Dalziel (2001) argued that Medicare was drastically under-treating seniors through inadequate number of services. "In fact", stated Dalziel, "I think it is almost 'ageist' in nature in terms of how we do not do enough for seniors in terms of their health care." There is the belief that the Canadian universal Medicare system has been focused on hospital care as opposed to community care, and acute care as opposed to chronic illness (Chappell, 2001; Ontario Human Rights Commission, 2005). This does not adequately meet the needs of the Canadian senior population and diverts attention from the long-term care needs of older adults (Ontario Human Rights Commission, 2005). Ageism and associated

under-funding of services for older adults is not germane to Canada. It has also been reported to exist outside of Canada (e.g., England (Roberts, Robinson, & Seymour, 2002) and the United States, (International Longevity Centre- USA, 2006)).

Lack of community-based supports compound the barriers to health care and other services for older adults (The Ontario Human Rights Commission, 2001). This was evident in Alison's comment on the lack of services in her town and how this lead to inappropriate placements after discharge. She spoke of clients who were unsuitably placed in long term care facilities due to a lack of community services.

Inappropriate placement in long term care facilities is currently an issue in Canada. Literature has been published providing reasons for inappropriate placements including a fragmentation in services, lack of overall responsibility and accountability, and lack of funding (Gordon, 2000; Henderson, 2002; Solidage, 2000). Inadequate transportation services were also reported to be an issue for seniors in Canada (The Ontario Human Rights Commission, 2001). In this study, participants also spoke of transit inaccessibility as an important barrier experienced by their older clients.

Social Hierarchies

Participants perceived working with older adults to be lower down in the social hierarchy compared to other work areas (e.g., pediatrics, spinal cord injury). Hierarchy also existed within gerontological work settings. There was a perception of acute care and rehabilitation settings being perceived by others as higher in the social hierarchy, and

long term care was considered to be the lowest. Participants appeared to equate status within the occupational therapy hierarchy and more specifically, gerontological occupational therapy hierarchy, with advanced technology and increased technical skills. The status within the hierarchy did not appear to be theory driven.

Likely, the discourses of rehabilitation and independence, along with service allocation discrepancies and ageist attitudes all played contributing factors to the socially produced ageist social hierarchy of which participants spoke. Evidence of these perceptions included derogatory comments made by peers not working with older adults, as well as those working in hospital settings; lower staff-patient ratios amongst senior populations; and inadequate services in programs focusing on older adults, in particular long term care facilities. Within occupational therapy, Wilkins and Rosenthal (2001) alluded to this hierarchy when they reported that gerontological occupational therapists in their study felt a lack of respect for their work amongst their colleagues as well a sense that they had little status within the community. Horowitz et al. (1999) also spoke of the older population being assigned low status. Compared to working with older adults, participants in the current study commented that working in other areas was viewed as being more 'sexy', 'glamourous' and having higher profile. This is consistent with the literature. Research in other health domains has shown that health professionals devalue the care specialties that are related to aging (Rosowsky, 2005). Reasons included 'older adults are not a sexy population to work with', 'they're not exciting' and 'gerontology is not chic' (it may be chic to do research in the basic sciences related to aging, but not in applied clinical practice).

Traits and Expectations of Seniors

There is another potentially perilous product of the ageism that is embedded in the system. Participants spoke of a discrepancy that emerged between the traits and expectations of younger adults within the health care system and those of the older population. The younger population appeared to have more of a sense of entitlement to receiving assistance and equipment within the health care system. In contrast, older adults did not appear to feel this same sense of entitlement, thus often demanding less. Perhaps the discourses of rehabilitation and independence along with the other ageist influences have perpetuated the older adult traits that participants spoke of: 'being appreciative', 'less demanding', and 'not wanting to be a burden to the health professional'. Is it possible that seniors have adopted these traits in order to compensate for their appeared encumbrance on society? Perhaps they have internalized the societal importance of independence, thus demanding fewer services in order to promote the appearance of being more independent. Conceivably seniors have fallen prey to the ageist stereotype that they are a medical burden and decline is an inevitable consequence of aging that must be experienced with equanimity. When therapists stress independence and restoration of lost function, it denies many older adults the dignity to accept they cannot improve or maintain their function.

The reported tendency for older adults to appear less demanding and more appreciative towards occupational therapists with whom they work can pose challenges. One must not make the error of equating 'less demanding and more appreciative' with having fewer needs. By not being demanding, some older clients miss out on occupational therapy

services. Jane's comment of not looking for any other referrals, which was echoed by others, demonstrated the reality of the overworked therapists. Individuals who are less demanding can be overlooked in the referral system and thus be neglected. It is helpful for occupational therapists to be conscious of this situation and these commonly found traits and try to ensure that they are meeting the needs of their older clients. It would be valuable if occupational therapists identified older clients who may be passive and not voicing their concerns, and advocated for these seniors, or encourage family members to advocate on the client's behalf. However, at times, this may be idealistic. The next cohort of seniors will be different from the current cohort. Baby boomers are now providing care for their parents of 80 plus years. This younger cohort understands the frustrations and limitations of the current health care system. These experiences combined with baby boomers' predominance in advocacy and actions for change will have profound effects on the future health care system.

Confronting the Challenges

As the number of older adults increases significantly in the next couple of decades, attitudes towards this population are expected to change simply because of the sheer number of seniors representing consumers of products and services (Foot & Stoffman, 2001). However, societal changes alone may not make an adequate impact. This is especially true for older adults who are vulnerable. Unlike current older adults who have on average more children who can provide care, it is anticipated that the baby boomers will comprise larger proportions of seniors who are not married and have no children to assist with their care (Martin-Mathews, 2007). Gerontological occupational therapy itself needs to also transform.

A Specialized Approach

The findings from this study suggest the need to refocus attention on a variety of approaches within gerontological occupational therapy in addition to those associated with the medical model. There were times when participants emphasized foci other than the tenets associated with rehabilitation. Approaches used included "making the end of their life happy", "making them more comfortable", "listening and just needing to have someone understand them", "maintaining their dignity and make them feel like they're contributing member of this community" and "emphasizing their individuality and ability to still make choices." In my view, the occupational therapy profession is well positioned to lead in the reconceptualization of gerontological practice from a medical, curative model to take on more of a social model, valuing interdependence, community, cooperation, and adapting to change.

Therapists' descriptions of alternative approaches with older adults are similar to those discussed in the literature. Baum (2006) suggested focusing on maximizing function and creating opportunities for meaning. While she suggested these approaches be used within skilled nursing facilities, I argue that the population can broaden to include all gerontological clients. For individuals in the later stages of life, the objectives are aptly stated by Bye (1998), "the outcome is not about independence or permanent rehabilitation to normal life-hallmarks of traditional occupational therapy. It is about occupational therapists helping clients to realize their goals to connect with life, and people in their life, on a level beyond illness and receipt of care" (p.19). The principles of palliative care can also apply to occupational therapy interventions for older adults in general. These principles include helping clients live in the present, adjusting to changing

circumstances, maximizing their quality of life (Bye, 1998), facilitating clients' involvement in occupations, and focusing on clients' feelings of self-worth and well-being (vanderPloeg, 2001). This seems to be the approach taken by the long term care facility where Emma works. She explained that management changed the title of her department from 'Rehabilitation services' to 'Restorative services' and then again to 'Quality of Living services'. According to Emma, management did not want

> families to get the impression that when people say 'rehab', they think 'Mom's going to start walking again, and she's going to never use the wheelchair. She's going to be walking all the time, and she's going to get an hour of rehab a day'.

Aging is a lifelong experience, requiring continuous change and adaptation. A common misconception is that the processes of recovery and decline are separate and linear. However, they are sometimes intertwined. As Tanya mentioned, this was an unexpected experience of watching her older clients' rallying with their health conditions. Pizzi and Briggs (2004) suggested rather than the steady and predictable 'downhill' decline, older adults may experience more of a 'rollercoaster' effect as they are more likely to experience a lingering process of dying as opposed to an acute death experience (e.g., progression of heart failure vs. acute myocardial infarction) compared to their younger counterparts. Older adults can experience numerous trips to the hospital with miraculous recoveries but each time a small decrement in capacity occurs, slowly losing their physiologic reserves (Pizzi & Briggs, 2004).

Work with older adults means coming into contact with people who have complex needs and medical issues. This study offers insights that may help with understanding why occupational therapists are sometimes not satisfied with the outcomes experienced by their older clients. Findings suggest participants focused on rehabilitation and independence when working with older adults. These discourses appear to have been indoctrinated into the occupational therapy profession, being part of the epistemic knowledge of practice, including working with older adults. Reframing one's thinking and approach to focus on more of a social model of maintaining seniors' dignity and enabling them to continue contributing to society, as well as valuing interdependence and adapting to change could be an important step for occupational therapists. This could lead to more satisfying and meaningful work, caring for seniors with complex and ongoing medical needs.

Education and Research

Education and knowledge translation are other strategies to transform gerontological occupational therapy. Information that is accessible to clients, their families, coworkers, student occupational therapists, the public and policy makers can assist in breaking down the barriers and stereotypes that prevent older adults from achieving their full potential. The critical element that needs to be changed is acknowledging, informing, and raising awareness amongst the public, policy makers, and professionals, including occupational therapists, of the ever present covert ageism, making it explicit to all. Exposure can provide a realistic view of aging and an increased appreciation for the heterogeneity of older adults. This study assists with this by promoting research that refutes many of the negative stereotypes of working with older adults. Promotion of the importance and

contributions of older adults along with the experiences of gerontological occupational therapists (such as those within this study) can be completed through various forms of media (e.g., clinical practice magazines, peer-reviewed research journals, national associations' website).

There are several features of the occupational therapy profession that are at the root of this issue. The notions 'aging is a medical condition' and 'to rehabilitate an older client is deemed to be the epitome of success' are manifestations of ageism. If educators and researchers adopt and incorporate a social model framework within the classroom and research, this will assist in examining critical external factors impacting the gerontological occupational therapists and increase awareness of the complexities of care for this older population. As well, students need to examine and address their own ageist attitudes. Providing students with positive exposure and experiences with older adults can increase the profile of gerontological occupational therapy.

Another way to change professional attitudes is through role modeling and making gerontological occupational therapy more appealing and higher profile. If statements such as 'I love working with older adults', which I heard frequently throughout the study, are expressed regularly in public domains, this can assist in changing public perceptions. More high profile gerontological occupational therapists would assist in increasing the profile of those working with older adults. These are individuals who publish consistently in various forms of media (e.g., journals, newsletters, magazines), are involved at the policy level, write editorials about gerontological issues; attend and speak

at conferences on issues related to gerontology; and demonstrate enthusiasm and passion for gerontological issues. Role models and mentors have been shown to be a significant influence on career decision making (Torrible et al., 2006) and changing attitudes and behaviours (West, Barron, Dowsett & Newton, 1999). Aggressive recruitment of gerontological occupational therapists would in turn enable increased opportunities for mentoring and clinical placements. As well, more therapists should be encouraged to participate in gerontological research and act as guest speakers at the entry level realm to increase students' exposure to gerontological occupational therapy and get them involved in research. These actions would bring a greater appreciation for the heterogeneity of older adults and increase students' exposure to the many interesting facets of gerontological occupational therapy.

The ageism inherent in the system is more than just a gerontological occupational therapy issue, this is a concern for the entire profession. There is an imbalance in our professional system. There is a need to stop the perpetuation of undervaluing older adults and those who work with them. The perceived social hierarchy described by participants contributes to this disapproval of working with older adults. An increase in occupational therapists' awareness of the work setting hierarchy can begin to challenge established procedures and entrenched ageist attitudes and thus assist in eliminating this hierarchy. As Abreu and Peloquin (2004) advocated, there is a need to move past the 'otherisms' that fractionalize the profession and cause pain to colleagues and celebrate the 'bridge makers'- colleagues who refuse to perceive others as having lower status and instead establish interrelationships and engender appreciation for one another. One proposition

includes ceasing to compare and judge one area of practice to another; and along with this, the termination of making critical remarks related to other settings. While often unintended, derogatory comments fracture the profession.

Research is needed to confirm and describe staffing and resource discrepancies between older adults and younger populations across Canada and within various health care settings. After which, national standards are required for services in areas such as geriatric acute care, geriatric rehabilitation, and seniors home care programs.

The decisions we take in the next few years will have far reaching consequences for the future of our aging society. I challenge occupational therapists to look afresh at what is currently happening within their work environments, to recognize opportunities as well as threats. Rethinking and challenging the current system will assist with promoting change. Occupational therapy can play a leading role in bringing about this required change in perspective, since strengths of occupational therapy include advocating for the client and focusing on the individual as well as environmental influences. To minimize stereotypes it is beneficial to focus on not viewing older adults as a single entity, but promote their heterogeneity. We can advocate for change, persuade and protest funding discrepancies as well as educate policy makers regarding older adults' complex health care needs. In addition, because we work closely with a variety of individuals within a team setting, we have the opportunity to influence multitudes of people. By confronting ageism head on, we can revolutionize the occupational therapy profession and stop perpetuating the damaging cycle.

Key Attributes for Gerontological Occupational Therapists

Gordon (2000) suggested that with older adults, "personal qualities of caring and sensitivity are as important as professional skills or academic achievement" (p.321). Presently, no commonly accepted gerontological knowledge, skills, and attitude-based attributes have been identified as desirable or 'necessary' for occupational therapists who work with older adults. Participants in this study identified a set of attributes that they thought were necessary for gerontological occupational therapy. An emphasis on these attributes among occupational therapists (i.e., both in the entry level and continuing professional education realms) can assist with the preparation of occupational therapists to master both the generalized and specialized requirements for this type of work.

Four key attributes were emphasized and these same traits have been referred to individually within the literature.

1) Communication (AOTA, 2004.; Atwal & Caldwell, 2005; Gordon 2000; Hobson, 1999b; Kaakinen et al., 2001),
2) Vigilance (i.e., being mindful and more attentive due to the complexity of issues with older adults; delving deeper) (Atwal & Caldwell, 2005; Kaakinen et al., 2001),
3) Knowledge (AOTA, 2004) of diverse illnesses and disabilities, complexity, age related changes and typical vs. disease related aging, and
4) Empathy (Gordon, 2000) along with patience to listen and understand client's priorities.

In health care, there is growing recognition to acknowledge these attributes that are sometimes seen as core competencies. Within medicine, the American Geriatrics Society (2000) developed basic competencies outlining the necessary attitudes, knowledge and skills required by medical students in order to care for older adults. Interestingly, of the four key attributes outlined by participants in the current study, only one of these is included in the American Geriatric Society core competencies (i.e., knowledge of diverse illnesses and disabilities). The other three attributes were absent, perhaps due to the fact that they are more social-emotional attributes and were not consistent with the more traditionally based medical model.

Participants stressed in particular, that gerontological occupational therapists needed to have good communication skills due to the high incidence of communication barriers found within the older adult population (e.g., large amount of immigrants who speak English as a second language, hearing impairments, and neurological conditions affecting their ability to understand). Poor communication by health professionals can influence clients' perceptions of their illnesses, their psychological adjustment and possible survival outcomes (Freedman, 2003). Communication skills are not emphasized within the general age-related occupational therapy text books (e.g., Bonder & Wagner, 2001; Davis & Kirkland, 1988; Kauffman, 1999; Kiernat, 1991; Lewis, 2002). When communication skills are mentioned, the focus is on the changes in communication by seniors and not the importance of communicating by therapists. Data suggest that an adaptive communication focus (Kemper, 1994), that is, being able to modify or adapt communication for cognitive and sensory deficits, is important. Greater emphasis on

adaptive communication in textbooks and training can assist with preparing future occupational therapists to work with older adults.

While no studies were found outlining the attributes that managers sought when hiring gerontological occupational therapists, one study within the social work literature revealed the two most common proficiencies managers looked for in gerontological social workers were assessment skills and the ability to case manage (Naito-Chan, Damron-Rodrigues, & Simmons, 2004). Participants in the current study spoke of the importance of occupational therapy managers, and others performing the hiring, to look for therapists who have flexible or adaptive communication skills, vigilance, breadth and depth of knowledge, empathy, and patience. While communication and knowledge can be easy to identify within an interview, vigilance, empathy and patience may be harder to discern. Despite popular belief, vigilance, empathy and patience are not 'soft' traits. They can be examined through questions posed to the interviewee asking them to be reflective and provide an example of a situation where they demonstrated/experienced that specific trait. These traits can also be measured more systematically through standardized personality assessments.

Bennett and Flaherty (2003) argued that there are too few health professionals who are educated in older adult-focused care. They suggested that the critical shortages in the number of health care providers who are educated in the unique health needs of older adults will continue to worsen as the demand increases in future years. Along with this, it would be beneficial to develop a consensus on standards regarding essential attributes related to older adults that all occupational therapists should have at entry level.

Building on this, a list could be developed outlining attributes necessary for those who are specializing in working with older adults.

Generalists versus Specialists

A primary focus within the Canadian occupational therapy profession is to enable clients to participate in meaningful occupation (CAOT, 2006). This focus is very broad and thus the profession graduates generalists in enabling occupation. A challenge arises as there appears to be a mismatch between the outcomes of education and training programs being undertaken by occupational therapists and skills required in order to meet the changing service needs of older adults. The gerontological occupational therapists in this study reported that graduates required specialized knowledge, both breadth and depth, related to working with older adults. As conveyed by respondents, clients and environmental issues were complex within this population. They also spoke of requiring distinctive communication skills, vigilance, empathy and access to up-to-date information on a broad range of illnesses and other aging issues.

There appears to be a dichotomy between graduating generalists and the fact that gerontological occupational therapists require specialized knowledge. This dichotomy leads to the debate whether gerontological occupational therapy should be a specialty (i.e., with special accreditation) or remain a generalist discipline. Moreover, this leads to tensions between emphasizing core curriculum of occupational therapy education, and emphasizing specialized curriculums, including gerontological curriculum.

In order to make sense of this duality in practice, we need to place it within the context of the wider literature examining the development of the profession. Within the theoretical literature regarding professions, attention is focused on the similarities and differences between the occupational therapy profession and other health professions, with little focus on the intraprofessional divisions (e.g., Brown & Greenwood, 1999; Ellis, Kersten, & Sibley, 2005; Smith & Roberts, 2005). It is evident that specialty areas within occupational therapy clearly exist (e.g., hand therapy, spinal cord injury, burns), however, similar to other professions such as law and nursing, it is on an informal basis. This is in contrast to medicine where their specialties are highly structured and evident in formal educational programs and certification processes.

Merits of Specialists

In most Westernized countries, there has been an increase in specialization amongst many health professionals including occupational therapists (McKenna & Bradley, 2003). Within the profession, this is evidenced by the movement to master entry-level training programs, special interest groups and accreditations, and groupings of specialized practice areas within occupational therapy journals. The marketplace favours specialists (Moore, 1992), as inferred from its robust growth in various realms (e.g., medicine, education, business).

In the medical professionalization literature, Döhler (1993) suggested that key variables influenced specialization. These can be applicable to the occupational therapy profession. They include: (a) conceptual and technological innovations which induces the

concentration on increasingly narrow fields of knowledge; (b) inter- or intraprofessional competition which acts as incentives for groups to monopolize certain specialty areas; (c) academic and political influences directly encouraging specialization or more indirectly influencing the shaping of specialty services; and (d) organizational aspects of health care delivery such as the changing structure and size of hospitals or other work places which have an impact on the process of specialization. Participants spoke of all of these variables within their work. In addition, another variable not addressed by Döhler was the need to enhance ones' professional identity. Some participants spoke of developing a specialty area and used it to help define their work practice. For instance, interest groups were formed and there appeared to be a lot of informal internal specialization within gerontological occupational therapy.

Specialization can assist with one's ability to keep current in one's field (McKenna & Bradley, 2003) as well as having a deeper understanding of knowledge related to one's focused field. However, there are some downsides to specialization. There is potential for specialization and its credentialing to give rise to further hierarchy and elitism (McKenna & Bradley, 2003). There is the risk of discontinuity in care and potential fragmentation of care as accredited occupational therapists may not be willing to work in services that are not within their specialties. For example, if one is working in acute care and a younger client is admitted, an occupational therapist with accreditation and a heavy caseload may argue that because she specializes in older adults, this client should be passed onto someone else. Creation of specializations may decrease occupational therapists' accessibility to this older population. Credentials may start to be required for a variety of

positions, limiting an entire population of candidates who may have the abilities but not the designation. As well there is a risk of the deskilling of generalist occupational therapists. Another challenge that may arise is the unity of the profession may be affected with the implementation of specialized accreditation. In a time where the profession is trying to develop momentum in public recognition, unity, and progression; the potential segmentalizing can run the risk of dividing the profession.

If formal specialized credentials were to take place, a national discussion would first be required on this issue. A classification needs to be determined regarding what constitutes a specialization in order to ensure consistency in outlining expectations and evaluating of competencies (e.g., population group, occupational challenges, geographic area, diagnosis, work setting, treatment interventions, impairment categories). It is important to note that an assumption is made regarding special designations in that those with accreditation have higher level of knowledge which is not always the case. If credentialing is only one point in time, how can we ensure the calibre of knowledge is maintained? It would be necessary to ensure ongoing accreditation.

Merits of Generalists

There was a time when occupations consisted of only generalists. The historic roots of our profession center on holism and along with that, a generalist approach. The Pew Health Professions Commission (1995) called for every health profession to make a commitment to generalism and to develop the qualities of superb generalists, capable of providing comprehensive management of clients' care.

Generalism can assist with interprofessional relations amongst occupational therapists as well as enhance the unity within the profession by minimizing the risk of compartmentalizing each therapist into differing work categories. It has been argued that a generalist is more likely to coordinate and integrate services in a complex system, providing valuable help where and when it is needed, and broadens medical care to include important preventive, psychological and social outcomes (Moore, 1992). Graduating as generalists, participants commented on how they appreciated the freedom to mobilize within a variety of settings taking on diverse caseloads. In today's health systems' organizational structure, career mobility is extremely common where therapists move from position to position and typically do not hold one sole rank throughout their career.

Yet, with generalism comes the risk of being unable to keep current on the breadth and depth of the ongoing prolific gerontological publications being published. As well, the quality of care delivered may worsen in the future as health care becomes more technically demanding (Moore, 1992).

Where do we go from here?

According to participants, there needs to be an acknowledgement that gerontological occupational therapy requires specialized knowledge, skills and attitudes just like work in pediatrics, spinal cord injury, hand therapy, etc. and treated as an equally respected type

of work. However, participants stressed the importance of the generalism within their practice. To develop this realm into a specialized accredited field did not appear to be in the interest of these participants. This is not surprising considering the generalist focus that the occupational therapy profession promotes.

I argue the profession should not head down the path of specialized accreditations for therapists practicing in gerontological occupational therapy, which has already been occurring in various realms in other countries such as in the United States with Board Certification (e.g., Gerontology, Mental Health, Pediatrics, Physical Rehabilitation) and Specialty Certification in specific skills (e.g., driving and community mobility; environmental modification; feeding). Instead, I argue that gerontological occupational therapy can acknowledge the need for both generalized and specialized knowledge while remaining in their generalized professional context. Gerontological occupational therapists are best described as 'specialized generalists'. When working with older adults, participants spoke of requiring mutual acquisition of specialized skills and knowledge along with the broader understanding and flexibility of a generalist. A 'specialized generalist' is a jack-of-all-trades and "master of complexity" (Nowaczynski, 2007), requiring individuals to be able to demonstrate leadership potential in a broad spectrum of fields (e.g. neurology, cardiac, seating, mental health, social systems, etc.).

In this study, the 'specialized skills and knowledge' related to the specialized generalist refers to expertise in understanding the various components within the framework depicting the multiple factors influencing the experiences of gerontological occupational therapists (Figure 1). This term does not equate to 'advanced practice' a term used in the

United States and other disciplines. While there is an expectation that masters entry level training in Canada should be preparing students for 'advanced practice' in occupational therapy, the concept of 'advanced practice' has not been fully developed within our discipline, lacks consensus of a clear definition and criteria and is worthy of further investigation.

The description of the specialized generalist may speak to the experiences of those working with other populations. For example, 'complex care' may be a common theme in other practice realms but the nature of complexity may be different. For example in pediatrics, the complexity may be more focused on the school system, whereas with older adults the complexity of care is focused on the medical issues and co-morbidities. Future research can examine the differences and similarities between other practice areas deemed to be specialized generalists.

The Complex Adaptive Systems (CAS) theory can assist in highlighting how complex older adults are and the intricacies of working with older adults thus requiring specialized generalists. CAS evolved from chaos theory and has been used within healthcare since the mid-1990s (Brown, 2006), reframing our perspective on complex systems that were only partially understood by traditional scientific insight (Zimmerman, Lindberg & Plsek, 1998). While the rehabilitative approach and the medical model within which it is situated is appropriate for certain straightforward issues (e.g., carpal tunnel syndrome), CAS is a more flexible and adaptive theory when working with older adults and their complex and chronic conditions.

CAS compliments our traditional understanding of complex beings to provide a more complete picture (Zimmerman, Lindberg & Plsek, 1998). It fosters the view that healthcare decision-making occurs within a matrix of influences and that a search for 'one-best' solution for a complex problem is not realistic. Certain approaches are more effective at certain times, in certain conditions requiring a range of strategies that can be modified as feedback and new information is available (Brown, 2006). CAS acknowledges that complex beings are influenced by a multitude of factors and require constant adapting to their environment, lifestyle, social context and chronicity (ibid.). This ever changing complexity is reflected in the conceptual framework that was developed in the current study regarding the experiences of gerontological occupational therapists (see Figure 2). CAS also asserts the belief that interdependence and independence co-exist (Zimmerman, Lindberg & Plsek, 1998).

By investing energies into having the occupational therapy profession unified and creating a 'professional presence', it will increase its power and influence in the health care sector. The profession can not have intraprofessional competition or 'in-fighting' between practice areas. I would argue that occupational therapists need to be a part of a cohesive professional field consisting of members with very similar standards and goals.

The key challenge to remaining a 'specialized generalist' while working in gerontological occupational therapy is keeping abreast of the evolving advances in gerontological research. Findings from this study suggest that this is possible, but several changes must occur to enable gerontological occupational therapists to perform optimally in their generalized professional context. Development of a sustained, focused, and

centralized effort strengthening the profession's response to the aging population is required. As the majority of occupational therapists will be working with older adults, it would be beneficial to increase current average level of knowledge of occupational therapists related to older adults; as well allowing current and future gerontological occupational therapists to learn the required specialized knowledge without losing the profession's generalist approach. This can be fostered through changes within 1) occupational therapy curricula and 2) clinical practice.

Curriculum Integration

It has been argued that occupational therapy programs need to provide an education that is responsive to the changing requirements of contemporary practice (Strong, Baptiste & Salvatori, 2003). As the proportion of older adults increases within the population, along with an increase in complexity in the issues among older adults; there will be an increased demand for occupational therapists to have more knowledge and familiarity with the senior population. This study has demonstrated that older adults bring unique challenges thus health professionals working with them require specialized knowledge and skills. Aging issues need to become more prominent and central within the curriculum. With time constraints and large amounts of knowledge already required within the entry level occupational therapy degree, this gerontological requirement can create tensions with the already established generalized core curriculum.

However, changes to the training initiative do not require any radically new instructional strategies. It does mean the marshalling of a lot of training concepts into a large scale consortium. Outlining standardized 'core' gerontological occupational therapy

curriculum across Canada would assist with this. Increased integration of seniors' issues at the foundational level throughout the curriculum could assist with this training initiative. The aging curriculum should not be compartmentalized into one 'aging unit'. This could lead students, who are thinking that they are not going to work with seniors, to not heed close attention to issues addressed in this course. The literature reveals that while very few students think they are going to work with older adults the majority end up working with this population (Wilkins & Rosenthal, 2001).

One method for integration is to have realistic scenarios that demonstrate the complexity of the senior clients that are encountered by occupational therapists. For instance, within a mental health class, increase the prevalence of scenarios focusing on older adults and their complex needs (e.g., an older adult who has schizophrenia who presents with depression as well as osteoarthritis, heart failure and environmental barriers). Another form of integration is through the use of a lifespan perspective (Baltes, 1987). Within the pediatric teachings, students must be made aware of the long term needs of their younger clients as well as the long term implications of their therapy interventions. For instance, the work therapists perform with their young clients who have cerebral palsy or spinal cord injuries have long term impacts into their senior years. These can be explored through the aging with a lifelong disability literature.

Practice Integration

The creation of a national consortium related to gerontological occupational therapy could benefit gerontological occupational therapists. There is evidence that social structures can have significant influences on informing and influencing clinicians' behaviours (West et al., 1999). An individual or group may be influential because they have power over others or because they set a standard against which others judge their own behaviour. A national gerontological occupational therapy research group could be this group. This group could apply for external funding and become a national collaboration whose primary focus is on knowledge translation of the proliferating gerontological occupational therapy research. They could coordinate a database with all occupational therapy research related to aging and undertake management of this database, identify gaps, and disseminate the relevant information in an online quarterly newsletter to all occupational therapists working with older adults.

Limitations of the Study

Current socio-political and historical contexts must be considered (e.g., paucity of jobs versus over-abundance, current societal status of seniors, etc.). The lens with which I viewed my data and findings was situated in one major Canadian city and the rural towns surrounding it. Perspectives may differ in other regions of Canada, other countries and other cultures. A similar study in other countries may show different findings.

While the findings from this study do not account for the experiences of all occupational therapists working with older adults, they articulate important messages about

individuals' unique experiences. Thus, it is a contribution to an emerging body of literature exploring occupational therapists' perceptions of working with older adults.

Another potential limitation to this study may be my level of expertise. I am a novice researcher. An important component of qualitative research is the ability of the researcher to be sensitive to the data in order to detect and understand what participants are expressing. I attempted to determine and explicate my own biases and perspectives prior to and during the study, but potential or unacknowledged biases may influence the results of the study. Nevertheless, my previous experience in gerontological occupational therapy is considered an asset.

Finally, but most importantly, the findings that were reported and the framework that was developed from this study are not to be used as a 'one size fits all' concept. Each individual lives through situations and experiences that are unique to him or her. The findings from this study are to be used as a guideline to assist others when they are learning about working with older adults.

Implications for practice, teaching and research

One of the tenets for the chosen methodological approach, interpretive description, is to have practical findings and clinical implications. The findings from this study have several implications for practice, teaching, and research.

This study has practical significance. The findings contribute to a small yet growing body of literature addressing the gerontological work experiences, including those of occupational therapists. The acquired knowledge regarding existing values, beliefs, expectations and meanings of practice held by gerontological occupational therapists forms a backdrop for dialogue on the extensiveness of these values and beliefs. Awareness is necessary for change. The interprofessional and intraprofessional undervaluing of work with older adults has to be acknowledged before changes can occur. As the next cohort of older adults age (i.e., the baby boomers), health care will likely be concentrated in the community, not institutions. It is in our best interest to eliminate the 'hierarchy' of gerontological practice between institutional care and community care, and between acute and chronic care.

Occupational therapists work in a shifting and uncertain practice world, sometimes with limited support and few resources. Sharing research findings with other practitioners may increase awareness of what is experienced by occupational therapists working with older adults. I hope the findings from this study are used as a foundation for discussion amongst clinicians about their personal experiences when working with older adults. The findings from this study can help create a sense of unity amongst therapists working in isolation.

Ideally, practice, research, and education inform each other. The findings from this study can assist with the development of appropriate gerontological curricula that are responsive to changing requirements of contemporary practice and expectations of future therapists' needs and in turn have an impact on future gerontological practice. It is

important for educators to emphasize the positive, enriching aspects of working with older adults that emerged from this qualitative study. As well, they can assist students in learning about the heterogeneity of seniors and their complex needs and care. Students can also be alerted to the challenges that they will encounter when working as a gerontological occupational therapist, many of which are environmental, and how they can manage or change these situations. The findings and framework outline key gerontological skills, knowledge and issues that could be implemented into occupational therapy curricula to ensure entry-level clinicians are aware of and develop suitable attributes to work in a range of practices related to older adults. While it is possible for students to develop many of the specified attributes, some attributes appeared to be made up of a person's moral and ethical values. Participants stressed attributes such as being compassionate or empathetic were inherent and thus some people lacked these traits. In describing the key attributes of gerontological occupational therapists, it allows us to identify people who would be compatible for working with older adults and encourage them to work in this realm. As well, in listing these attributes, it may highlight some occupational therapists who may not be ideally matched to work with this population.

This study has several implications for future research studies. A study examining the experiences of gerontological occupational therapists in other cultures (e.g., a collectivist culture such as the one found in Japan) could help highlight universalities as well as differences compared to the findings from this study which was completed in a culture that has more of an individualistic focus. Further exploration into how much the rehabilitation approach is embedded into gerontological occupational therapy practice, and its impact, is required. Further evaluation regarding students' stereotypes and

perceptions of aging and their roles in caring for older adults would assist in understanding how much ageism is rooted into the system. There also is a need to examine the impact that the ageist views that were discussed in this study have on the service delivery (e.g., performing a similar qualitative study amongst health care managers).

The stories from this study were gathered from the voices of occupational therapists. However, this research study may also have potential to inform other health care practitioners working in the field of aging such as physiotherapists, speech and language pathologists, nurses and physicians. Considering the fact that there is little research published on the experiences of any health professionals working with older adults, these professionals can benefit from the knowledge shared regarding key client characteristics, environmental influences, and attributes required to best meet the needs of older adults requiring health services. A similar study could be fashioned to determine how these findings are applicable to other health professionals.

Currently, there are no published occupational therapy studies using interpretive description. However, it is used within other realms such as nursing, psychology, and health promotion. This study and its findings assist in introducing interpretive description to the occupational therapy research. Interpretive description could be used to explore other occupational therapy research areas where little information exists about a phenomenon, to generate knowledge and understanding of the experience along with practical clinical implications.

It is my hope that further research will contribute additional variation and uncover more layers of complexity to my findings, thus heightening the dialogue about the experiences of gerontological occupational therapists.

The profile of gerontological occupational therapy is changing in association with shifts in demographics, increased longevity, and increased incidence of chronic disease. An awareness of the factors that influence the experiences of gerontological occupational therapists, as outlined in the framework previously presented, would allow the occupational therapy profession to raise and address important questions pertaining to the meaning of working with older adults.

Using the framework depicting the multiple factors influencing the experiences of gerontological occupational therapists these questions can be categorized into three realms: client characteristics, environmental influences and personal factors. There are questions related to client characteristics: would the characteristic of complex health conditions make it necessary for gerontological occupational therapists to be generalists? Are the characteristics of being isolated, less demanding and appreciative specific to this cohort, and will this change with the next generation? How will changes in these characteristics affect the health care and social services and environmental designs that we provide for an aging population? Questions related to environmental influences include: how is ageism acknowledged, addressed and changing in the context of occupational therapy practice? Do work conditions, resource allocation and research agenda reflect the realities of an aging population? Can gerontological occupational therapists feel they are making meaningful contributions given the social and

professional environment they work in? Finally, what personal factors (i.e., attributes) make a good gerontological occupational therapist? What type of training equips a gerontological occupational therapist with the breadth and depth of knowledge needed to work effectively with older adults?

Such questions reflect a professional level of thinking and should be posed by students at various stages of their training, therapists who interact with students, clients and their families, by administrators who make decisions that have an impact on work conditions, and by educators who mentor and coach students in the classroom setting. If we do not consider these questions, we miss opportunities to have an impact on creating meaningful work experiences in gerontology occupational therapy. Occupational therapists can take on roles that empower them to make decisions that can change the current and future work environment, resource allocation, as well as pursue research questions that inform gerontological occupational therapy practice.

Changes experienced by the researcher

The reflexivity process was used to increase awareness of my personal biographies, assumptions and values, and provide a context in which the analysis and interpretation of the data can be understood. I entered into the study with a perception that ageism was present within the occupational therapy profession. The ageist attitudes that I identified in participants' comments throughout the study may have been related to my sensitivity to ageist issues at the beginning of the study. Over the course of the study, additional biases were revealed to me and some were challenged. I went into the study thinking that gerontological occupational therapy should be a specialization with accreditation in order

to maximize the preparedness of occupational therapists working with older adults. However, returning to the respondents' voices, I noted that this was not what they envisioned. They emphasized that they were generalists requiring specialized knowledge which could be gained through increased emphasis within the curriculum and in continuing education. I also entered into the study believing that rehabilitation with older adults is important and often overlooked in the community, particularly in long term care. When Emma mentioned that her facility was changing the name of the rehabilitation department to the 'quality of life department', I felt a personal sense of disappointment that once again rehabilitation was loosing emphasis within the realm of older adults. It was only through reviewing participants' comments and research findings that I learned that I too had entrenched the importance of the rehabilitation discourse. In addition, I came into this study with a perception that the work pace in various settings were different (i.e., institution was fast paced and community was slower paced). In hearing the stories of participants, I realized the delineation was more in the flexibility of planning the typical work day. Community settings appeared to have more flexibility of when and what they performed in a typical day, while institutional settings often had a typical work day structured fairly standard amongst all the therapists on a unit. I also anticipated that death would play a significant role in the experiences of working with older adults. To my surprise, death was not a focal part of the experience and was viewed in a neutral light.

Finally, I had perceived that participants would focus some of their discussion on the important relationship between occupation and older adults. There was very little

discussion of occupation-focused practice by participants. There appeared to be a disconnect between key concepts from the theories of the discipline (e.g., occupation-as-means, occupation-as-ends, meaning) and therapists' discourses about their practice (e.g., focus on technical skills, client diagnoses). The emphasis on 'technical glamour' is surprising in an era where theory development and occupation-focused practice are strongly emphasized in curriculum and publications. These findings are consistent with publications about the academic-practice gap and the lack of theory-driven practice (e.g., Fisher, 1998; Higgs & Titchen, 2001; Kielhofner, 2005b). Occupational therapists' perceptions of what is valued and deemed to be relevant in a practice setting needs to be examined.

Summary

This qualitative study examined how 16 occupational therapists in Canada understand their work with older adults. The research captured the factors that describe these gerontological occupational therapists' experiences. The framework depicting these factors may be used by occupational therapists as a reference when they examine their roles as health service providers and educators.

The strength of the study lies in its use of qualitative methodology, which resulted in relatively rich description, enabling the opportunity to study the experience as it occurred and consider the subjective experience. Because this study took place within an applied health discipline, interpretive description was an appropriate approach in that it did not require the epistemological claims traditionally associated with earlier social science

methods be accepted fully, and permits an 'explanatory' or interpretive twist (Thorne et al., 2004).

Diversity was the hallmark of the experiences of gerontological occupational therapists. Participants described working with older adults as an enjoyable experience offering variety, intellectual challenge and satisfaction, while recognizing that working with older adults was often perceived as being assigned lower status. Participants viewed the rewarding aspects as outweighing the negative aspects of working with this population. Tanya's sentiments characterized the experiences of the gerontological occupational therapists that I interviewed, *"It's like having a hundred grandparents!*

The complexity of care was an essential element when working with this population. Specialized generalist was the image that best portrayed this group of therapists, requiring both a wide breadth of knowledge, as well as in-depth specialized knowledge on the complexities of care and co-morbidities. Participants spoke of the uniqueness of this group of older individuals, both as a cohort as well as a group of individuals who had reached their senior years. From participants' perspectives, the current health care system within which gerontological occupational therapists worked, did not adequately meet the needs of older individuals. The most predominant challenge faced by participants was the ageism that appeared to influence their abilities to be fully valued within their work settings. This ageism appeared to be socially produced in response to influences of powerful discourses including 'rehabilitation' and 'independence' as well as public and professional attitudes. These social productions in turn impacted service allocation, social structures and older adults' persona.

Communication skills along with the 'right attitude' of being empathetic, compassionate, and enjoying visiting and listening to the stories of their older clients were deemed crucial attributes when working as a gerontological occupational therapist. Participants also spoke of requiring the special responsibility to be even more patient, flexible, thorough, creative and knowledgeable than their colleagues in other practice realms due to the complexity of older adults' needs. From these experiences, a conceptual framework was developed outlining key influences relevant to the experiences of occupational therapists who work with older adults. This framework provides occupational therapists with a deeper understanding of the various aspects related to working with older adults. The acquired knowledge from this study can foster dialogue on issues of gerontological practice which is needed to develop appropriate programs and strategies to attract, promote, and retain more occupational therapy professionals in gerontology.

REFERENCES

Abreu, B., & Peloquin, S. (2004). The issue is- Embracing diversity in our profession. *American Journal of Occupational Therapy, 58,* 353-359.

Adams, W., McIlvain, H. E. Lacy, N. L., Magsi, H., Crabtree, B. F., Yenny, S. K. et al. (2002). Primary care for elderly people: Why do doctors find it so hard? *The Gerontologist, 42,* 835-842.

Ahern, K. (1999). Ten tips for reflexive bracketing. *Qualitative Health Research, 9,* 407-411.

American Occupational Therapy Association. (2004). *Report on gerontology as an area for board certification.* (Available from American Occupational Therapy Association, Professional Development, 4720 Montgomery Lane, PO Box 31220, Bethesda, MD 20824-1220.)

American Geriatric Society. (2000). Core competencies for the care of older patients: Recommendations of the American Geriatrics Society. *Academic Medicine, 75,* 252-255.

Arino-Blasco, S., Tadd, W., & Boix-Ferrer, J. A. (2005). Dignity and older people: The voice of professionals. *Quality in Ageing, 6,* 30-36.

Atwal, A., & Caldwell K. (2005). Do all health and social care professionals interact equally: a study of interactions in multidisciplinary teams in the United Kingdom. *Scandinavian Journal of Caring Sciences, 19,* 268-73.

Baltes, P.B. (1987). Theoretical Propositions of Life-Span Developmental Psychology: On the Dynamics between Growth and Decline. *Developmental Psychology, 23,* 611-626.

Barnes, C., Mercer, G., & Shakespeare, T. (1999). *Exploring disability. A sociological introduction.* Malden, MA: Polity Press.

Baum, M. C., (2006). Centennial challenges, millennium opportunities. *American Journal of Occupational Therapy, 60,* 609-616.

Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice.* Menlo Park, CA: Addison-Wesley.

Bennett, J., Flaherty-Robb, M., (2003) "Issues Affecting the Health of Older Citizens: Meeting the Challenge" *Online Journal of Issues in Nursing*, 8, Retrieved December 12, 2006, from www.nursingworld.org/ojin/topic21/tpc21_1.htm.

Bond, J. (1992). The politics of caregiving: The professionalization of informal care. *Ageing and Society, 12*, 5-21.

Bonder, B. R., & Wagner, M. B. (2001). *Functional performance in older adults.* Philadelphia: F.A. Davis Company.

Brown, C. A. (2006). The application of complex adaptive systems theory to clinical practice in rehabilitation. *Disability and Rehabilitation, 28*, 587-593.

Brown, G. T., & Greenwood, J. (1999). Occupational therapy and physiotherapy: Similar but separate! *British Journal of Occupational Therapy, 62,* 163-170.

Bruner, E. (1986). Experience and its expression. In V. Turner & E. Bruner (Eds.), *The anthropology of experience* (pp. 3-30). Chicago: University of Illinois Press.

Burgess, E. (1960). *Aging in Western societies.* Chicago, University of Chicago Press.

Butler, R. N. (2005). Ageism: Looking back over my shoulder. *Generations, Fall*, 84-86.

Bye, R. (1998). When clients are dying: occupational therapists' perspectives. *The Occupational therapy journal of research, 18*, 3-22.

Caelli, K., Ray, L., & Mill, J. (2003). 'Clear as mud': Toward greater clarity in generic qualitative research. *International Journal of Qualitative Methods, 2*, Article 1.

Canadian Association of Occupational Therapists. (1988). *Position paper on occupational therapy with the elderly population.* Toronto, ON: CAOT Publications ACE.

Canadian Association of Occupational Therapists. (2005a). *Membership statistics for 2004/2005*. Ottawa, ON: Author.

Canadian Association of Occupational Therapists. (2005b). Position Statement: occupational therapy and end-of-life care. *Canadian Journal of Occupational Therapy, 72*: 121.

Canadian Association of Occupational Therapists. (2006)."Pan-Canadian Awareness Initiative on Occupational Therapy and Interdisciplinary Collaboration in Primary Health Care. Retrieved on November 20, 2006, from www.caot.ca.

Canadian Federal Labour Standard Review (n.d.). Modernizing Part III of the Canada Labour Code. Retrieved on October 11, 2005, from http://www.fls-ntf.gc.ca/en/sub_fb_28.asp.

Canadian Institute for Health Information. (2005). Table A1. Total Health Expenditure, Canada, 1975 to 2005—Summary. Retrieved January 12, 2006, from http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_07dec2005_e#nhex.

Carlson, M., Fanchiang, S. P., Zemke, R., & Clark, F. (1996). A meta-analysis of the effectiveness of occupational therapy for older persons. *The American Journal of Occupational Therapy, 50*, 89-98.

Carroll, L. (1827/1997). *Through the looking-glass.* London: Macmillan Children's Books.

Chappell, N. (2001). *Canadian social policy and ageing.* For the Canada-Japan Social Policy Research Project, organized by the Asia Pacific Foundation of Canada, Vancouver, presented in Osaka, Japan, June, 2001. Retrieved on March 17, 2006, from http://www.asiapacificresearch.ca/caprn/cjsp_project/neenafinal.pdf.

Clark, F., Azen, S. P. Zemke, R., Jackson, J., Carlson, M., Mandel, D. et al. (1997). Occupational therapy for independent-living older adults. *Journal of American Medical Association,* 278, 1321-1326.

Cohen, M. Z. & Omery, A. (1994). Schools of phenomenology: Implications for research. IN: J.M. Morse (Ed.). *Critical issues in qualitative research methods.* Thousand Oaks, CA: SAGE Publications.

Cohn, E. S., & Lyons, K. D. (2003). The perils of power in interpretive research. *The American Journal of Occupational Therapy, 57,* 40-48.

Coren, A., Andreassi, M., Blood, H., & Kent, B. (1987). Factors related to physical therapy students' decisions to work with elderly patients. *Physical Therapy, 67,* 60-65.

Crabtree, J. L. (1991). Occupational therapy's mandate: Providing services to the elderly. *The American Journal of Occupational Therapy, 45*, 583-584.

Cravens, D. D., Campbell, J. D., & Mehr, D.R. (2000). Why geriatrics? Academic geriatricians' perceptions of the positive, attractive aspects of geriatrics. *Family Medicine, 31*, 34-41.

Creswell, J. W. (1998). *Qualitative inquiry and research design. Choosing among five traditions.* Thousand Oaks, CA: SAGE Publications.

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches. (2nd ed.).* Thousand Oaks, CA: SAGE Publications.

Cruikshank, M. (2003). *Learning to be old. Gender, culture, and aging.* Rowman & Littlefield Publishers, IND.: Lanham, MD.

Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigor. *Qualitative Health Research, 12*, 279-289.

Davis, L. J., & Kirkland, M. (1988). *The role of occupational therapy with the elderly.* Rockville, MD: American Occupational Therapy Association Inc.

Dalziel, W. (2001). *Proceedings of the standing senate committee on social affairs, science and technology.* Issue 3 – Evidence. Retrieved on March 17, 2006. from http://www.parl.gc.ca/37/1/parlbus/commbus/senate/com-e/soci-e/03ev-e.htm?Language=E&Parl=37&Ses=1&comm_id=47.

Denzin, N. K., & Lincoln, Y. S. (1994). Preface. In N.K. Denzin & Y.S Lincoln (Eds.), *Handbook of qualitative research,* (p. ix-xii). Thousand Oaks, CA: SAGE Publications.

Denzin, N. K., & Lincoln, Y. S. (2000). Introduction. The Discipline and practice of qualitative research. In N. K. Denzin & Y. S Lincoln (Eds.), *Handbook of qualitative research*, (2nd ed.). (pp. 1-28). Thousand Oaks, CA: SAGE Publications.

Department of Justice. (2005). *Canadian Forces Members and Veterans Re-establishment and Compensation Act (2005, c. 21).* Retrieved March 1, 2007.

Dickie, V. (2003). Data analysis in qualitative research: A plea for sharing the magic and the effort. *American Journal of Occupational Therapy, 57,* 49-56.

Döhler, M. (1993). Comparing national patterns of medical specialization: A contribution to the theory of professions. *Social Science Information, 32,* 185-231.

Dowd, J. (1975). Aging as exchange: A preface to theory. *Journal of Geronotlogy, 30,* 584-594.

Dunkle, S. E., & Hyde, R. S. (1995). Predictors and subsequent decisions of physical therapy and nursing students to work with geriatric clients: An application of the Theory of Reasoned Action. *Physical Therapy, 75,* 614-621.

Dunkle, S. E., & Nosse, L. J. (1998). Influence of a gerontology course on physical therapy students' intent and attitude toward working with elderly clients. *Issues on Aging, 21,* 9-17.

Ellis, B., Kersten, P., & Sibley, A. (2005). A Delphi study of the role parameters and requirement of extended scope practice in hand therapy. *British Journal of Hand Therapy, 10,* 80-86.

Elmberger, E., Bolund, C., & Lutzen, K. (2002). Men with cancer: Changes in attempts to master the self-image as a man and as a parent. *Cancer Nursing, 25,* 477-485.

Emden, C. M & Sandelowski, M. (1999). The good, the bad and the relative, part two: Goodness and the criterion problem in qualitative research. *International Journal of Nursing Practice, 4,* 206-212.

Erlandson, D. A., Harris, E. L., Skipper, B. L., & Allen, S. D. (1994). *Doing naturalistic inquiry*. Newbury Park, CA: SAGE Publications.

Finlay, L. (2001). Holism in occupational therapy: Elusive fiction and ambivalent struggle. *American Journal of Occupational Therapy, 55,* 268-276.

Finlay, L. (2002). "Outing" the researcher: The provenance, process, and practice of reflexivity. *Qualitative Health Research, 12,* 531-545.

Fisher, A. (1998). Uniting practice and theory in an occupational framework. *American Journal of Occupational Therapy, 52,* 509-521.

Foti, D. (1996). Gerontic occupational therapy: Specialized intervention for the older adult. In K. O. Larson, R. G. Stevens-Ratchford, L. Pedretti, & J . L. Crabtree (Eds.), *ROTE: The role of occupational therapy with the elderly*. Bethesda, MD: American Occupational Therapy Association.

Foot, D. & Stoffman, D. (2001). *Boom, bust & echo 2000: Profiting from the demographic shift in the new millennium*. Macfarlane, Walter and Ross: Toronto.

Fordyce, M (1999). *Geriatric pearls*. F.A.Davis Company: Philadelphia.

Freedman, T. G. (2003). Prescriptions for health providers: From cancer patients. *Cancer Nursing, 26* (4), 323-330.

Friedland, J. (1998). Occupational therapy and rehabilitation: An awkward alliance. *The American Journal of Occupational Therapy, 52,* 373-380.

Giles, L. C., Paterson, JE., Butler, SJ., & Stewart, JJ. (2002). Ageism among health professionals : A comparison of clinical educators and students in physical and occupational therapy. *Physical & Occupational Therapy in Geriatrics, 21,* 15-26.

Gillespie, M. (2002). Student-teacher connection in clinical nursing education. *Journal of Advanced Nursing, 37,* 566-576.

Giorgi, A. (1985). *Phenomenology and psychological research.* Pittsburgh: Duquesne University Press.

Glaser, B., & Strauss, A. (1967). *The discovery of grounded theory.* Chicago: Aldine.

Gordon, M. (2000). Problems of an aging population in an era of technology. *Journal of the Canadian Dental association, 66,* 320-322.

Grant, L. D. (1996). Effects of ageism on individual and health care providers' responses to healthy aging. *Health and Social Work, 21,* 9-15.

Gunderson, A., Tomkowiak, J., Menachemi, N., & Brooks R. (2005). Rural physicians' attitudes toward the elderly: evidence of ageism? *Quality Management in Health Care. 14,* 167-176.

Hagedorn, R. (1997). *Foundations for practice in occupational therapy.* New York: Churchill Livingstone.

Hahn, H. (1994). The minority group model of disability: Implications for medical sociology. *Research in Sociology of Health Care, 11,* 3-24.

Hasselkus, B.R. (1989a). Occupational therapy and physical therapy in geriatric rehabilitation. *Physical and Occupational Therapy in Geriatrics, 7,* 3-20.

Hasselkus, B. R. (1989b). The meaning of daily activity in family caregiving for the elderly. *American Journal of Occupational Therapy, 43,* 649-656.

Hasselkus, B.R. (2003). The voices of qualitative researchers: Sharing the conversation. *The American Journal of Occupational Therapy, 57*, 7-8.

Hasselkus, B.R. & Dickie, V.A. (1994). Doing occupational therapy: Dimensions of satisfaction and dissatisfaction. *The American Journal of Occupational Therapy, 48*, 145-154.

Hasselkus, B.R., Dickie, V.A., & Gregory, C. (1997). Geriatric occupational therapy: The uncertain ideology of long-term care. *The American Journal of Occupational Therapy, 51*, 133-139.

Hasselkus, B.R., & Kiernat, J.M. (1989). Nationally Speaking- Not by age alone: Gerontology as a specialty in occupational therapy. *The American Journal of Occupational Therapy, 43*, 77-79.

Health Canada. (2006). *Canada Health Act — Annual Report 2005–2006.* Retrieved March 1, 2007, from http://www.healthcanada.gc.ca/medicare.

Henderson, K. (2002). Informal caregivers. In: M. Stephenson & E. Sawyer (Eds.), Continuing the care. The issues and challenges for long-term care. Ottawa: CHA Press.

Higgs, J. (2001). Charting standpoints in qualitative research. In H. Byrne-Armstrong., Higgs, J. & Horsfall, D. (Eds.). Critical Moments in Qualitative Research (pp. 44- 67). Woburn, MA: Butterworth-Heinemann.

Higgs, A., & Titchen, A. (2001). Rethinking the practice-knowledge interface in an uncertain world: A model for practice development. *British Journal of Occupational Therapy, 64,* 526-533,

Hildenbrand, G. (1947). Geriatrics and occupational therapy. *The American Journal of Occupational Therapy, 1,* 159-161.

Hobson, S. (1999a). The International Year of Older Persons: What occupational therapists have to celebrate. *Canadian Journal of Occupational Therapy, 66*, 155-160.

Hobson, S. (1999b). Using client-centered approach with elderly people. In: T. Sumsion (Ed.). *Client-Centered Practice in Occupational Therapy. A Guide To Implementation.* Churchill Livingstone: Edinburgh.

Holliday, A. (2002). *Doing and writing qualitative research.* London: SAGE Publications.

Horowitz, B., & Bressler, D. C. (2000). Occupational therapists' knowledge of aging. *Physical and Occupational Therapy, 17*, 37-48.

Horowitz, B.., Savino, D., & Krauss, A. (1999). Ageism and implications for gerontic occupational therapy practice. *Topics of Geriatric Rehabilitation, 15* , 71-78.

Huberman, A.M., & Miles, M. B. (1994). Data management and analysis methods. In N. Denzin. & Y. Lincoln (Eds.), *Handbook of qualitative research.* Thousand Oaks, CA: SAGE Publications.

Imrie, R. (1997). Rethinking the relationships between disability, rehabilitation, and society. *Disability and Rehabilitation, 19*, 263-271.

International Longevity Centre- USA. (2006). *Redesigning health care for an older America- Policy report.* New York: Author.

Kaakinen, J., Shapiro, E., & Gayle, J. (2001). Strategies for working with elderly; Clients: A qualitative analysis of elderly client/nurse practitioner communication. *Journal of the American Academy of Nurse Practitioners, 13*, 325-329.

Katz, S. (2001). Growing older without aging? Positive aging, anti-ageism, and anti-aging. *Generations, Winter,* 27-32.

Kauffman. T. L. (1999). *Geriatric rehabilitation manual.* New York: Churchill-Livingstone.

Kauffman, T.L., & Jackson, O. (1999). Wholeness of the individual. In T. L. Kauffman (Ed.), *Geriatric rehabilitation manual.* New York: Churchill-Livingstone.

Kelly, G. (1996). Understanding occupational therapy: A hermeneutic approach. *British Journal of Occupational Therapy, 59,* 237-242.

Kemper, S. (1994). Elderspeak: Speech accommodations to older adults. *Aging Cognition, 1,* 17-28.

Kielhofner, G. (2005a). Rethinking disability and what to do about it: Disability studies and its implications for occupational therapy. *American Journal of Occupational Therapy, 59,* 487-496.

Kielhofner, G. (2005b). Scholarship and practice: bridging the divide. *American Journal of Occupational Therapy. 59,* 231-239.

Kiernat, J. M. (1991). The rewards and challenges of working with older adults. In J.M. Kiernat (Ed.), *Occupational therapy and the older adult: A clinical manual* (pp. 2-10). Gathersburg, MD: Aspen.

Kirk, H. (1992). Geriatric medicine and the categorization of old age- the historical linkage. *Ageing and Society, 12,* 483-497.

Klein, J. (2002). Will students be prepared? Current status of gerontological content in entry-level occupational therapy programs in Canada. *Canadian Journal of Occupational Therapy, 69,* 168-175.

Klein, S. M. (1997). *A national agenda for geriatric education. White papers.* Washington, DC: Springer Publishing Company.

Knafl, K. A., & Webster, D. C. (1988). The progression of knowledge in nursing: A search for meaning. *IMAGE: Journal of Nursing Scholarship, 20,* 222-224.

Kurtland, M. (1952). A symposium on geriatrics. *Canadian Journal of Occupational Therapy, 19*, 51-53.

Lawton, M. P. & Nahemow, L. (1973). Ecology and the aging process. In C. Fishdorfer & M. P. Lawton (Eds.), *Psychology of adult development and aging* (pp. 619-674). Washington, DC: American Psychological Association.

Lemon, B., Bengston, V., & Peterson, J. (1972). An exploration of the activity theory of aging: Activity types and life satisfaction among in-movers to a retirement community. *Journal of Gerontology, 27,* 511-523.

Lewis, C. B. (2002). *Aging. The health care challenge.* Philadelphia: F.A. Davis Company.

Lincoln, Y. S. (1995). Emerging criteria for quality in qualitative and interpretive research. *Qualitative Inquiry, 1,* 275-289.

Lincoln, Y.A., & Guba, E.G., (1985). *Naturalistic inquiry.* Newbury Park, CA: Sage.

Lookinland, S., & Anson, K. (1995). Perpetuation of ageist attitudes among present and future health care personnel: Implications for elder care. *Journal of Advanced Nursing, 21*, 47-56.

Madan,. A. K., Aliabadi-Wahle, S., & Beech, D. J. (2001). Ageism in medical students' treatment recommendations: the example of breast-conserving procedures. *Academic Medicine, 76*, 282-284.

Martin-Mathews, A. (2007, March). *Asking the questions, funding the answers: CIHR's funding of Canadian research on transitions of care in later life.* Paper presented at the Greying Nation: Transitions of Care in Later Life, Edmonton, Alberta.

Mattingly, C. (1994). Occupational therapy as a two-body practice: The lived body. In C. Mattingly, M.H. Fleming. (Eds.), *Clinical reasoning: Forms of inquiry in a therapeutic practice*. (pp. 64-93). Philadelphia: F.A. Davis.

McKenna, H., & Bradley, M. (2003). Generic and specialist nursing roles in the community: An investigation of professional and lay views. *Health and Social Care in the Community, 11,* 537-545.

Merriam- Webster (2003). *Merriam-Webster dictionary.* Retrieved May 1, 2003 from http://www.m-w.com/home.htm.

Miller, G. D. (1998). Predictors of disability in the independent elderly. In: R.G. Stone (Ed.), (1991-2002). *Gerontology Manual.* Tacoma, WA: University of Puget Sound. Retrieved December 14, 2001, from http://otpt.ups.edu/Gerontological_Resources/Gerontology_Manual/MillerG.html.

Mitchell, G. J., & Cody, W. K. (1993). The role of theory in qualitative research. *Nursing Science Quarterly, 6,* 170-178.

Moloney, T. W., & Paul, B. (1991). Building the future of geriatrics. *Journal of American Geriatrics Society, 39,* 425-428.

Moore, G. T. (1992). The case of the disappearing generalist: Does it need to be solved? *The Millbank Quarterly, 70,* 361-379.

Morse, J. M. (1991). Qualitative nursing research: A free for all? In J. Morse (Ed.), *Qualitative nursing research: A contemporary dialogue.* Newbury Park, CA: SAGE Publications.

Morse, J. M. (1994). Going in 'blind'. *Qualitative Health Research, 4,* 3-5.

Morse, J. M. (1999). Qualitative generalizability. *Qualitative Health Research, 9,* 5-6.

Morse, J. M., & Richards, L. (2002). *Read me first for a user's guide to qualitative methods.* Thousand Oaks: SAGE Publications.

More, J. M., & Singleton, J. (2001). Exploring the technical aspcts of 'fit' in qualittaive research. *Qualitative Health Research, 11,* 841-847.

Munhall, P. L. (1994). *Revisioning phenomenology: Nursing and health science research.* New York: National League for Nursing Press.

Naito-Chan, E., Damron-Rodriguez, J., & Simmons, W.J. (2004). Identifying competencies for geriatric social work practice. *Journal of Gerontological Social Work, 43,* 59-78.

National Advisory Council on Aging. (1999). *1999 and beyond: Challenges of an aging Canadian society.* Ottawa: Author.

Nemmers, T. M. (2004). The influence of ageism and ageist stereotypes on the elderly. *Physical and Occupational Therapy, 22,* 11-20.

Noonan, A.C. (1992). Recruitment in geriatrics. *Clinical Management, 12,* 48-58.

Nosse, L. J. (1995). Predicting who will work with elderly patients. *Issues on Aging, 18,* 18-17.

Nowaczynski, M. (2007, March). *House calls with my camera: A physician's approach to the multidisciplinary community-based care of frail seniors as they age in place.* Paper presented at the Greying Nation: Transitions of Care in Later Life, Edmonton, Alberta.

Oldman, C (2002). Later life and the social model of disability: A comfortable partnership? *Ageing & Society, 22,* 791-806.

Oliver, M. (1990). The politics of disablement. London: Macmillan Education LTD.

Ontario Human Rights Commission. (2005). *Ageism.* Retrieved March 17, 2006, from http://www.ohrc.on.ca/en_text/consultations/age-consultation-report_5.shtml.

Ontario Human Rights Commission. (2001). Time for Action- Advancing human rights for older Ontarians. Retrieved March 17, 2006, from http://www.ohrc.on.ca/english/consultations/age-consultation-report.pdf.

The Oxford English Dictionary. 2nd ed. (1989). OED Online. Oxford University Press. Retrieved April 18, 2005, from http://dictionary.oed.com/cgi/entry/50201415.

Palmore, E. (1999). *Ageism negative and positive*. (2nd ed.). New York: Springer Publishing Company.

Patton, M. Q. (2002) *Qualitative evaluation and research methods.* (3rd ed.). Newbury Park, CA: SAGE Publications.

Pew Health Professions Commission. (1995). *Critical challenges: Revisitlizing the health professions for the twenty-first century.* SanFrancisco: University of California, The Center for the Health Professions.

Pizzi, M. A, & Briggs, R. (2004). Occupational and physical therapy in hospice: The facilitation of meaning, quality of life and well-being. *Topics in Geriatric Rehabiliation, 20,* 120-130.

Polit, D. F., & Hungler, B. P. (1999). *Nursing research. Principles and methods,* (6th ed.). Philadelphia , PA: Lippincott Williams & Wilkins.

Prochnau, C., Liu, L., & Boman, J. (2003). Personal–professional connections in palliative care occupational therapy. *American Journal of Occupational Therapy, 57,* 196-204.

Putnam, M. (2002). Linking aging theory and disability models: Increasing the potential to explore aging with physical impairment. *The Gerontologist, 42,* 799-806.

Qualitative Solutions and Research. (1997). *QSR NUD*IST User Guide.* London, Sage Publications.

Reed, K. L. & Sanderson, S. N. (1999). *Concepts of occupational therapy.* (4th Ed). Philadelphia, PA: Lippincott, Williams & Wilkins.

Reuben, D. B. (2004). Confronting the geriatrician's nightmare. *Journal of the American Geriatrics Society. 52,* 393-394.

Roberts, E., Robinson, J., & Seymour, L. (2002). *Old habits die hard. Tackling age discrimination in health and social care.* London: King's Fund Publisher.

Rodger, S. (1984). The need for occupational therapists in geriatric nursing homes. *Occupational Therapy, June,* 185-187.

Rosa, S. (2002). The lived experience of "working together" with patients in occupational therapy. *Dissertation Abstracts International,* 63 (04), (UMI 3049396).

Rose, K., & Webb, C. (1998). Analyzing data: maintaining rigor in a qualitative study. *Qualitative Health Research, 8,* 556-562.

Rosowsky, E. (2005). Ageism and professional training in aging: Who will be there to help? *Generations, 29,* 55-58.

Rowe, J., & Kahn, R. (1998). *Successful aging.* New York: New York: Random House.

Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advanced in Nursing Science, 16* , 1-8.

Sandelowski, M. (2000). What ever happened to qualitative description? *Research in Nursing & Health, 23,* 334-340.

Schultz, P. R. & Meleis, A. I. (1988). Nursing epistemology: Traditions, insights, questions. *Image: Journal of Nursing Scholarship, 20,* 217-221.

Schwandt, T. A. (1997). *Qualitative inquiry: A dictionary of terms.* Thousand Oaks, CA: SAGE Publications.

Shuy, R. W. (2002). In-person versus telephone interviewing. In J. F. Gubrium & J. A. Holstein (Eds.), *Handbook of interview research. Context and method.* Thousand Oaks, CA: SAGE Publications.

Smith, S. & Roberts, P. (2005). An investigation of occupational therapy and physiotherapy roles in community setting. *International Journal of Therapy and Rehabilitation, 12,* 21-29.

Snape, D. & Spencer, L. (2003). The foundations of qualitative research. In J. Ritchie & J. Lewis. (Eds.), *Qualitative research practice. A guide for social science students and researchers.* (pp. 1-23). London: SAGE Publications.

Solidage. (2000). A system of integrated services for the frail elderly. Retrieved April 15, 2006, from http://www.solidage.ca/docs/SIPA_1e.pdf.

Spier, B. E. & Yurick A. G. (1989). A curriculum design to influence positive student behaviors toward the elderly. *Nursing & Health Care. 10*, 264-268.

Statistics Canada. (2002). Census Metropolitan Area (CMA) and Census Agglomeration (CA). Retrieved December 15, 2002, from http://www12.statcan.ca/english/census01/products/reference/dict/geo009.htm

Statistics Canada. (2005a). Estimates of population, by age group and sex, Canada, provinces and territories, annual (Persons unless otherwise noted). Table 051-0001. Retrieved December 14, 2005, from http://www40.statcan.ca/l01/cst01/demo10a.htm

Statistics Canada. (2005b). The Daily. Catalogue 11-001-XIE. Retrieved January 8, 2005, from http://www.statcan.ca/Daily/English/051215/d051215.pdf

Sternberg, R. (2005). Older but not wiser? The relationship between age and wisdom. *Ageing International, 30,* 5-26.

Stone, R.G., & Mertens, K.B. (1991). Educating entry-level occupational therapy students in gerontology. *The American Journal of Occupational Therapy, 45,* 643-650.

Strauss, A. & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: SAGE Publications.

Strauss, A. & Corbin, J. (1998). *Basics of qualitative research: Grounded theory procedures and techniques.* (2nd ed.). Newbury Park, CA: Sage.

Strong, S., Baptiste, S., & Salvatori, P. (2003) Learning from today's clinicians in vocational practice to educate tomorrow's therapists. *Canadian Journal of Occupational Therapy, 70,* 11-20.

Taylor, L. F., & Tovin, M. (2000). Student physical therapists' attitudes toward working with elderly patients. *Physical and Occupational Therapy in Geriatrics, 18,* 21-37.

Thomas, R. L. (2002). Frail and the institutionalized elderly clients. In: C. B. Lewis (Ed.) *Aging. The health-care challenge.* (4th ed.), (pp. 343-367). Philadelphia, PA: F. A. Davis Company.

Thorne, S. (Speaker). (2005). Interpretive Description. (Teleconference, April, 2005). International Institute for Qualitative Methods. University of Alberta, Canada.

Thorne, S., Harris, S. R., Mahoney, K., Con, A., & McGuinness, L. (2004). The context of health care communication in chronic illness. *Patient Education and Counselling. 54*, 299-306.

Thorne, S., Reimer Kirkham, S., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing & Health, 20* 169-177.

Thorne, S., Reimer Kirkham, S., & O'Flynn-Magee, K. (2004). The analytic challenge in interpretive description. *International Journal of Qualitative Methods, 3.* Article 1. Retrieved May 15, 2005 from http://wwwualberta.ca/~iiqm/backissues/3_1/pdf/thorneetal.pdf.

Todd, A. K., Rider, B. A., & Page-Robin, E. (1987). Attitudes of occupational therapy students toward older persons. *Physical and Occupational Therapy in Geriatrics, 5*, 71-81.

Tornstam, L. (1992). The quo vidis of geronotlogy: On the scientific paradigm of gerontology. *The Gerontologist, 32,* 318-326.

Torrible, S. J., Diachun, L. L., Rolfson, D.b., Dumbrell, A. C., & Hogan, D. B. (2006). Improving recruitment into geriatric medicine in Canada: Findings and recommendations from the Geriatric Recruitment Issues Study. *Journal of the American Geriatrics Society, 54*, 1453–1462.

van Manen, M. (1997). *Researching lived experiences. Human science for an action sensitive pedagogy.* (2nd ed.). London, ON: Althouse Press.

vanderPloeg, W. (2001). Health promotion in palliative care: An occupational perspective. *Australian Occupational Therapy Journal, 48* 45-49.

Viorst, J. (2002). *Necessary losses.* The Free Press: New York.

Wainapel S. F. (1999). Low vision rehabilitation and rehabilitation medicine. In: R. Massof and L. Lidoff (Eds.), *Issues in Low Vision Rehabilitation: Service Delivery, Policy, and Funding.* New York: American Foundation for the Blind Press; 1999:55–60.

Webster's Third New International Dictionary, Unabridged. (2002) NY: Merriam-Webster.

Weitzman, E. A. (2000). Software and qualitative research. IN: N. K. Denzin and Y. S. Lincoln (Eds.), *Handbook of qualitative research. (2nd ed.),* (pp. 803-820). Thousand Oaks, CA: SAGE Publications.

Wesley, S. C. (2005). Enticing students to careers in gerontology: Faculty and student perspectives. *Gerontology & Geriatrics Education, 25,* 13-29.

West, E., Barron, D. N., Dowsett, J., & Newton, J. N. (1999). Hierarchies and cliques in the social networks of health care professionals: implications for the design of dissemination strategies. *Social Science and Medicine, 48,* 633-646.

Wilcock, A. A. (1998). Reflections on doing, being, and becoming. *Canadian Journal of Occupational Therapy, 65,* 248-256.

Wilkins, S., & Rosenthal, C. (2001). Career choices: A comparison of two occupational therapy practice groups. *Canadian Journal of Occupational Therapy, 68,* 29-40.

Williams, A., & Botti, M. (2002). Issues concerning the on-going care of patients with comorbidities in acute care and post-discharge in Australia: A literature review. *Journal of Advanced Nursing, 40,* 131-140.

Zimmerman, B., Lindberg, C. & Plsek, P. (1998). *Edgeware: Lessons from complexity science for health care leaders*. Dallas, TX: VHA Inc.

APPENDICES

APPENDIX A- Information Sheet for Interview

The Practice of Gerontological Occupational Therapy

I would greatly appreciate your willingness to take part in an interview. Please read the following information to gain an understanding about the study.

Purpose: The purpose of the study is to understand important aspects of being an occupational therapist who works with seniors. The results of this study may help occupational therapists prepare for practice and progression in this specialty area.

Benefits: In taking part in this interview you will get the opportunity to reflect on your practice and profession. You will also have the opportunity to share your experiences with an interested person. Your insight may assist in the gathering of knowledge of what it is like to be an occupational therapist working with older adults.

Risks and Discomforts: The risks associated with taking part in this study are minimal. You may experience some inconvenience due to the time involved in being interviewed. The interview will be approximately 1 hour. The questions I will ask you will be based on your experiences of working with older adults. In the unlikely event that you become upset because you are sharing emotional experiences, you are free to discuss your feelings with me, in order to reduce any undesirable effects. You are encouraged to ask questions at any time. It is anticipated that only one session is needed but a second follow-up session may be scheduled if needed.

Confidentiality: The only people who will listen to the tapes will be the typist and me. You will be given a code number when you take part in the interview. The typist will remove your name and all identifying information when she/he transcribes the interview. The typed notes will be available to my research committee. Any information that you give will be kept confidential by the research committee except when professional codes of ethics or legislation require reporting.

The tapes and transcripts will be kept in a locked cabinet at the University of Alberta for at least 5 years. Excerpts of our dialogue will be used to support the findings. Your name will not be disclosed at any time. Every effort will be made to disguise any identifying characteristics in your excerpts so that colleagues will not recognise your identity. However, it is important to note that complete anonymity can not be guaranteed. Study results may be shared with the occupational therapy profession, in the form of presentation and publications.

Secondary Analysis: Data collected in this study may be used for another study in the future. I will seek approval from the Ethics Review Committee before doing any further studies with this data. If this happens, all information about you will be kept confidential.

Withdrawal from the study: You do not have to participate in this study. There are no consequences for not participating. You are not expected to answer any question that you do not want to answer.

The interview will take place at a location that is convenient for you. This could be your home or work setting. If you would like a copy of the final report please provide me with your email or postal address. After all the interviews and focus groups are completed I will send you a copy. If you have any concerns or questions about any part of this study please feel free to contact myself- Jennifer Klein or Dr. Lili Liu. If you have any ethical concerns regarding your participation, you may also contact the Health Research Ethic Panel at (780) 492-0839.

Thank you for your co-operation,

Jennifer Klein OT (C), PhD Candidate
Department of Occupational Therapy
Faculty of Rehabilitation Medicine
Therapy
Corbett Hall, University of Alberta
Edmonton, AB T6G 2G4
Work Phone: (780) 434-7646
Email: jennifer.klein@ualberta.ca

Supervisor:
Dr. Lili Liu OT (C) Rm. 3-14
Associate Professor
Department of Occupational

Faculty of Rehabilitation Medicine
Corbett Hall, University of Alberta
Edmonton, AB T6G 2G4
Work Phone: (780) 492-5108
Email: lili.liu@ualberta.ca

APPENDIX B- Focused Questions

I am interested in understanding what it is like for occupational therapists to work with older adults. Please answer the following two questions. Your answers will be confidential.

Can you think of a specific situation when you were working with an older adult and you felt especially *satisfied* as an occupational therapist? Please describe the situation, the outcome and how you felt regarding the incident.

Can you think of a specific situation when you were working with an older adult and you felt especially *dissatisfied* as an occupational therapist? Please describe the situation, the outcome and how you felt regarding the incident.

Please return your responses to myself, Jennifer Klein, prior to your interview. It can be sent by email: jennifer.klein@ualberta.ca or postal mail: Jennifer Klein 11515 77 Ave, Edmonton, AB T6G 0M2 or fax ATTN Jennifer Klein (780) 492-1626.

APPENDIX C-Consent Form

Tile of the Project The experiences of gerontological occupational therapists Part 1: Researcher Information		
Name of Principal Investigator: Jennifer Klein PhD Candidate Affiliation: University of Alberta Contact Information: Department of Occupational Therapy Faculty of Rehabilitation Medicine, Corbett Hall, University of Alberta Edmonton, AB T6G 2G4 Work Phone: (780) 434-7646		
Name of Co-Investigator/Supervisor: Lili Liu OT (C), PhD D. Associate Professor Affiliation: University of Alberta Contact Information: Department of Occupational Therapy Faculty of Rehabilitation Medicine, 2-64 Corbett Hall, University of Alberta Edmonton, AB T6G 2G4 Work Phone: (780) 492-5108		
Part 2: Consent of Subject		
	Yes	**No**
Do you understand that you have been asked to be in a research study?		
Have you read and received a copy of the information sheet?		
Do you understand the benefits and risks involved in taking part in this research study?		
Have you had an opportunity to ask questions and discuss the study?		
Do you understand that you are free to refuse to participate or withdraw from the study at any time? You do not have to give a reason.		
Has the issue of confidentiality been explained to you? Do you understand who will have access to your records/information?		
Part 3: Signatures		
This study was explained to me by: _____ Date: _____		
I agree to take part in this study. Signature of Research Participant: _____ Printed Name: _____		
I believe that the person signing this form understands what is involved in the study and voluntarily agrees to participate. Researcher: _____ Printed Name: _____		
* A copy of this consent form must be given to the subject.		

APPENDIX D- Interview Guide

1) Intro

I am interested in understanding the important aspects of working with older adults. I believe that your experience as an occupational therapist will help me to understand what is involved in working in this area. I may jot down notes as we go along- are you okay with that?

2) Some basic introduction questions to enhance comfort and get basic demographic information.

- Education, location of schooling, date of graduation
- Tell me about your work history. Place of work, how long worked in specific dept and where else/population have you worked with?

3) In-depth questions

As you know the focus of this research is to understand what it is like to be an OT who works with older adults. You decide what is important – what you would like me to know about this topic.

- Tell me about what you do at your job
- Can you tell me about your experiences, what it is like for you to work as an OT who work primarily with seniors?
- Can you share with me how you came to work with older adults?
- Where do you see yourself working in 2 years? In 10 years?
- What keeps you working with older adults instead of switching to another area?
- What competencies (i.e., knowledge, skills, attitudes) do you consider to be important when beginning to work as an OT with the senior population?

4) Other questions

What do you see as positive aspects of working with older adults?
What barriers/challenges have you encountered? Are they still barriers? If not, how have you overcome these barriers?
Are there unique aspects to being a gerontological OT?
What is the overall mood (optimism, anger, fear, or uncertainty) to working in this area?
How do you think the experience is for others?
What changes in perception have you undergone from a new grad to a more experienced gerontological OT?

5) Closing

Is there anything else I should have asked?
Is there anything you would like to know about me?
May I call you back if I need more information and/or clarification?

Examples used of lead-ins as suggested by Munhall (1994).

- Could you give me an example of that?
- Do you remember how that made you feel?
- What do you think is the meaning of (whatever preceded)?
- Could you elaborate more on that?

APPENDIX E- Participant Details

Participant	Age	Gender	Geography	Work setting	Worked with other populations	Years of experience
Interview-01	35-44	Female	Urban	LTC	No	20
Interview-02	35-44	Female	Metro	LTC	Yes	20
Interview-03	less than 35	Female	Metro	LTC	No	2.5
Interview-04	less than 35	Female	Rural	Specialized Senior Program	No	2.3
Interview-05	less than 35	Female	Urban	Subacute/Rehab	Yes	4
Interview-06	less than 35	Female	Metro	LTC	No	2.5
Interview-07	less than 35	Female	Metro	Specialized Senior Program	Yes	4.5
Interview-08	35-44	Female	Metro	Subacute/Rehab	No	6.5
interview-09	less than 35	Male	Metro	Acute Care	Yes	8
interview-10	greater than 44	Female	Metro	Acute Care	Yes	28
Interview-11	35-44	Female	Metro	Specialized Senior Program	Yes	15
Interview-12	35-44	Female	Metro	Home Care	Yes	18
Interview-13	35-44	Female	Metro	Subacute/Rehab	No	17
Interview-14	35-44	Female	Metro	Home Care	Yes	4
Interview-15	35-44	Male	Metro	Subacute/Rehab	Yes	10
Interview-16	greater than 44	Female	Rural	Home Care	Yes	28

APPENDIX F- Inspiring Stories

Hanna talked of the importance of listening to older adults' life experiences.

> I had one fellow on my caseload who was a fighter pilot in the war and was shot down and was taken prisoner and kept in a pit in the ground. I had another fellow who was a British SAS paratrooper, and there was the couple that, he was 94, and he had a picture of him as a child, holding onto an oxen team, and that was how his family homesteaded out near Vegreville. None of these stories are written down; it's just oral history, and oral history is disappearing as society changes, and none of those stories are told any more.

In response to this, I have chosen to include some stories shared by participants capturing some moments in their experiences working with older adults that are not recorded elsewhere in detail and would be lost otherwise. The stories demonstrated not only the enduring spirit of these older clients, but as well how these clients influenced and/or changed the perceptions of the occupational therapists.

The Determined Spirit

There was a lady lived on the south side, and she was originally from England, and she was an émigré, I guess around 20 years ago. Her son came with her; she and her son both lived together. I believe she was in her 70s, and he was in his late 40s or early 50s. This lady had a really complicated medical picture. She was mostly blind, she was overweight, she had severe arthritis, she was kyphotic, she had diabetes, she had a stroke; I mean, you name it, and this little old lady had it. But this little old lady, she also had a Chihuahua that was blind and had arthritis and had diabetes; it was like the dog mirrored the client. And yet, she and this little dog, she had this little bag that the dog rode in, in this bag, and he went with her to the seniors group, and he went with her to the doctors visits, and he went with her to the store. Wherever it is that she needed to go, she took this dog with her, and that was her driving motivation to get out and about. In fact, I managed to talk her into getting a walker, because she was having issues with falling. I managed to…talked her around to the idea of using a 4-wheeled walker, because that would allow her to put the dog in the basket to get the dog out for walks get the dog out for exercise. Just shortly after I got that set up for her, I went over to her place to check and see on this walker, how that was going, and I noticed that the dog was walking in circles. I thought, "Oh, I think this dog's had a stroke." Sure enough, I think it was within 24 hours, that dog died. So here's this little old lady's reason for getting up in the morning that was now gone. And you know what? She [pause] just picked herself up. She grieved over that dog, and went through that experience, but she still got herself out to her seniors group, and she still went out for her tea, and she still talked about the joy in getting outside and watching the leaves, and all of those experiences. She has such wealth of spirit and such focus on her day-to-day life, and getting the enjoyment that she could out of each and every day, and making sure that she maintained those community

connections. And despite the fact that she couldn't see, she had no driver, all those challenges which she had in front of her, and she still made sure that she got out once or twice a week to go play bridge and to go gossip with the little old ladies at the local seniors club....I think that was the first time that I really realized that I needed to look at how much I was complaining about what was going on in my own personal life, and I didn't have half the stuff going on that she did, and she didn't whine half as much as I did, either. So it was looking at the benefits and the joys that I had.... So I think that was the first time that I ever really sort of noticed how big somebody's spirit could be. [Hanna]

Listening for a change

She was very mobile, and slowly declined. We were doing some walking with her and having her attend exercise class. She was doing bike pedaling and doing cardiovascular things....She was walking to the dining room, and she says, "I don't want to do this. Why do I have to do this?" And I said, "What do you mean, you don't want to do that? Isn't it great you get to go to the dining room?" "But I don't want to. I'm 88 years old, and I've walked my whole life, and I just want to walk faster." It was, "Okay, that's fine," so we got her a wheelchair. Much happier, much more independent, coming out to programs.... For her, it's much more energy conserving for her to use a chair and be able to come out to a program than just getting up and walking; that wasn't very purposeful to her. [Before] she'd walk to the dining room, and when she got there, she's like, "Okay, now I don't have a lot of energy to do other things." Now she doesn't even want to go the bathroom any more; "I just want to sit in my chair; I'm fine this way; I don't mind getting help. This is fine." Now she wants to go to bed more, and she [says], "I'm winding down, and that's just how it is. I'm happy." She's happy doing it that way, but it was really hard for me to give her those little bits. I said, "Okay, alright." Especially when you have a family that believes different than the resident, and the family is saying, "Why are you letting her do that? You should make her," or "You should be telling her she has to." And I think, "Yeah, I've become a lot stronger resident advocate than family." [Tanya]

The mentor, the mentee and the OT

I had in my office a couple of stroke people and one was a young woman who's probably in her early 50s and she was a teacher. And she had this horrible stroke where she was totally aphasic both receptively and expressively, and she had no use of the one arm. And I also had another lady who had had a bad stroke as well but was not aphasic but couldn't use her arm very well at all. So we had this young woman I took over from another therapist just to see if we could put her into a group setting and see if she could do better, you know, it was lovely. Because this lady, when she first came in, she wouldn't look at anybody. But the group, especially this older lady, kind of took her under their wing and talked to her and asked her questions about all these things and this lady couldn't talk but would try her very best. So anyway, they had such a good friendship, and also we noticed that this young woman was all of a sudden she started putting on makeup, and she was

looking out from the eyes, she was dressing better; and overall, her whole demeanor changed. And I truly think it was because of this older lady. The older lady was a baker. And every time this patient sat across from her and would say something the next day this lady would bring a cake for her. "You did so well. We have to celebrate." So I think she was pulling on her experiences, I think, with her children, but she was putting it onto this woman. It was good. [Carolyn]

A cup of tea changes everything

The [client] is a rather difficult resident who lives in the institution where I work. She can be verbally and physically aggressive and can become quite agitated with staff, in particular. I have never had too much difficulty with her in all the times I've worked with her and have developed quite a rapport with her. I have worked with her mostly after she had a fall and became unable to walk and lost much of her independence with ADL's. In addition to various physical diagnoses, she also has a mental illness. This client had recently had many verbal and physical outbursts with staff and in discussions with her following, it seemed that she had many issues with losing her independence. I decided to explore these issues a little further with the client to determine how her sense of quality of life could be improved upon. I used a "Quality of Life" screen that was developed at this institution in an attempt to qualitatively measure a resident's sense of quality of life. In completing this assessment, I spent two separate sessions within one week having tea, discussing areas that she felt were most important to her and how things could change for the better. At the end of the assessment, she had come up with between four to five things that she would like to improve her life and make her feel better about herself; all the goals she came up with had to do with being independent in her care. After I wheeled her back to the unit, this client stated that I "made life worth living" and commented that she very much enjoyed our tea-time. I felt immensely happy that I could make someone's life worth living by simply having tea with them and listening to them.... This situation reminded me that I do matter in my workplace; if not to the interdisciplinary staff, at least to the residents. [Ana]

The Easter Message

The Situation: I was a senior student... [on] my final placement, which was at the XXXX hospital. I was working with a gentleman who had been admitted to our care given his unstable pathological spinal fractures and general decreased medical status. He required a clamshell brace. He had considerable pain; he was having understandable difficulties grappling with his palliative status; his position options were limited given his fracture restrictions and pain; he was experiencing difficulties sleeping and was tending towards day-night reversals. The client declined our visits as he was feeling so ill and was not rested during regular OT service times. The client responded very well to intervention from a pastoral care team member, who continued to follow the client. Soon after, the client was more agreeable to our intervention. Treatments in general were directed towards helping nursing with the clamshell brace requirements; consulting orthotists for

a refitting; bed mobility; skin protection; day time alertness so that he would be able to spend valuable time with his family and church friends during "visiting hours"; comfort; increasing his tolerance towards an increased head-of-the-bed angle (a position more conducive to visiting versus lying flat in supine; and general well-being. It was nearing Easter time and the client was very concerned that, for the first time ever, he did not have an Easter present for his 2 grandsons. I had located some old pom-poms, baskets and googley eyes in an old craft room (a room that, as I understand it, really had not been used in a while – given increased caseloads, etc. and less time for treatment in general). As I was a student, it afforded me more time to work directly with the client. We listened to soothing music over the course of treatments and worked at crafting two toys from bed: a bunny and a chick. sitting in baskets. The curtains were drawn back each time to let the noon-day sun in to brighten the work. We chatted about the significance and meaning that Easter held to the client. We were able to increase the head of the bed gradually each time to the client's tolerance.

The Outcome: The client shared with me on Easter Monday the joy he experienced giving his grandsons their presents. He gave me a Ukrainian nickname (as he knew I was Ukrainian by heritage) that his grandsons made up for me. He shared that his grandsons wished to thank me for my involvement in their grandpa's present. After I had finished my placement, I was attending the PhD dissertation presentation of the Pastoral Care team member; she shared with me that this client had discharged home, was doing very well and had visited her and mentioned the value of our treatments.

How I felt: This experience re-affirmed for me the use of crafts as an amazing therapeutic modality, it re-affirmed the Easter message of renewal and hope, it showed me that no matter how sick this client was, and how much care he himself required, there was beauty and value in his being able to care and give to others. [Alison]

Freedom equals Dim Sum

I run monthly health and wellness clinics with a nurse in senior's apartments and I will never forget the feeling I had working with a particular couple. Mr. and Mrs. X live in a subsidized apartment for seniors. They are Chinese speaking so I require an interpreter at all times. Mr. X suffered a stroke in 1984 and another one in 2001. He also has dementia. Not only do I provide service to Mr. X, I am concerned for Mrs. X's wellbeing as a caregiver. My involvement with them began in August 2000 and is still ongoing. One of the benefits of working in the community is follow up and monitoring of clients.

When I first met Mr. X, he was only using a cane, however it was apparent that he required more support. I had suggested a walker. They agreed and obtained Full Benefit Assistance for AADL. But, by 2001, after Mr. X's second stoke, his mobility needs changed. Long distance walking became more challenging and unfortunately it made travelling unsafe and lowered his quality of life. I then suggested a wheelchair for outings only and of course encouraged Mr. X to use his walker as much as possible when indoors to preserve his strength and endurance. Mrs. X was so pleased with this

wheelchair, because it meant that they could still go out for Dim Sum. She pushes him in the wheelchair, which is much safer for him and for her. Before the wheelchair, she was pushing him while he sat on the seat of the walker. This led to a fall.

Also, Mrs. X was losing sleep because Mr. X would frequently get up at night to void and she would take him to the bathroom to ensure safety. This was a huge concern for us. Mrs. X is in her 80's and is responsible for managing daily activities and caring for her husband. I brought in a bedside commode and also made a referral to Home Care to relieve caregiver of some duties such as bathing and for respite. With their commitment to health and safety and my interventions, together we made a difference. Still today, they enjoy going out for Dim Sum, to Superstore, and to the mall. Knowing that they are able to continue to do the things that make them happy and knowing how much your time and skills are valued and appreciated is such a rewarding feeling. Even though they speak Chinese, they took the time to learn my name. I do look forward to hearing- "Good morning [name of therapist]" at the next health clinic. [Linnea]

Celebrating an ingenious invention

My very first day in home care in Stony Plain, I was traveling with the nurse, and we were going out on visits, and one of the clients that we went to see was this older fellow, probably 84, had Parkinson's. I often say I've learned more from my clients along the way than I ever knew on my own, that I can pass on to other people. This old guy was quite rigid, so it was very difficult for him to move, and one of the things that he figured out, in order to get out of bed when he was there on his own, was he had put a hook onto the window sill, and he hooked his belt over the hook, and he had a string through the hole in his belt, and he made a loop, and he tied the loop around his wrist. So when he laid down, he left his loop around his wrist, and he would pull the string towards him so he could get a hold of his belt, and then he could pull himself up to get out of bed. [laughs] So this was towards the end of the day, and so he showed us this. I thought it was great! [laughs] And then it had been his birthday, and he'd been given peach schnapps for his birthday, and he just insisted that we had to have a drink to celebrate his birthday. So on my first day on the job in home care, we're drinking on the job! [laughs] When he came in, we said to him, "Just a tiny bit," so he put this tiny bit in the bottom of the glass. His wife then came home. She took a big tumbler,…maybe an 8-ounce glass. She filled it to the top with the schnapps, and she downed it in one drink! [laughs] It was just amazing! And that's just part of life in home care; you meet all kinds of people, and it's interesting. [Julie]

So long as they are dirty, they are happy

We've had some fascinating clients. I once was asked to go out and see a fellow. He was just being discharged from the nursing home, they lived in a house, he and his brother; his brother was 90; he was 84. They lived in the house that they had been born in, and they lived in basically one room of that house, and the rest…would be condemned if it

was a rental property. You couldn't see the floor, basically; it was like it was a dirt floor, but I think there had been a floor there [chuckles]! And they obviously had made an effort 'cause we were coming. They had cleaned off a chair for us, and there were circles in the windows, 'cause they had [laughs] cleaned the windows. They each had a bed, one on each side of the room, and at the end of the bed, their clothes were stacked up. They had a wood stove and another heater that were in this room, so it was basically their kitchen. They didn't have running water; they had an artesian well out on the property, and the younger brother took me to the well to show me what it was like, and they had twigs floating on top of this water; it was not [laughs] clean water. And yet they'd lived like that all their life. Basically, we certainly wouldn't have put care into that situation, because we couldn't ask our home support aides to go into the artesian well to take this dirty water and deal with it. They were contented with the way that they were living; I wasn't going to change that. When the younger brother had gone into hospital, ... I can't remember now what condition it was...they had to shave his underwear off of him because the hair on his body had grown through the fibers in the underwear, and [laughs] that's how seldom they bathed. But this 90-year-old had these wire-rim glasses that were- I'm sure, 50 years old. He played the violin, and he demonstrated his violin-playing for us. It was [pause] like I said, you meet fascinating people. [Julie]

APPENDIX G- Participants' Number Code

1. Alexandra
2. Jane
3. Tanya
4. Ana
5. Alison
6. Emma
7. Linnea
8. Brittney
9. Doug
10. Carolyn
11. Summer
12. Christina
13. Carla
14. Hanna
15. Chris
16. Julie